

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05678

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 9 months
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 5 years, 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 315 River Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Anna E. Ammon

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 20, 1860 6.(c) If alive, give age _____ years

8. AGE: Years 86 Months 4 Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Thomas Clements Dent

13. Birthplace Maryland

14. Maiden name Harriet Elizabeth Wolker

15. Birthplace Maryland

16. Informant Hospital records

Address Catonsville-28, Md.

17. Buried Date thereof 21 June 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Congreg Church

Location Bladensburg Md.

18. Funeral director J. D. Smith & Sons

Address Hopkinsville Md.

19. 6-20- 19 46 Harriet Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 46 at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 19 40 to June 19 19 46 and that I last saw her alive on June 19 19 46

Immediate cause of death Terminal pneumonia DURATION 48 hrs.

Due to Arteriosclerotic cardiovascular disease Indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Isadore Tuerk, M.D.

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 6-19-46

MARGIN RESERVED FOR BINDING

I

VS A15 9.45.15M AT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 22 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Peake

MARYLAND STATE DEPARTMENT
BALTIMORE CITY HEALTH DEPARTMENT

Baltimore Co.

CERTIFICATE OF DEATH

Registered No. 30

05679

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-13-46

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1946, to 6-13 1946, and that I last saw him alive on 6-5 1946.

Immediate cause of death

Coronary Myocarditis

Duration

2 Mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. W. Peake

M. D.

Address

4508 Harford Rd

Date signed 6-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05680

44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Vets. Admin. Hosp. Fort Howard, Md.
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harp.
 City or town Havre de Grace,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 211 Seneca Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-1

3. (a) FULL NAME

ROBERT M. ANSALVISH

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 28, 1900 6. (c) If alive, give age..... years

8. AGE: Years 45 Months 11 Days 1 If less than one day..... hrs. min.

9. Birthplace Columbia, Pa.
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name John Ansalvish
 13. Birthplace Havre de Grace, Md.

14. Maiden name Mary Smith
 15. Birthplace Havre de Grace, Md.

16. Informant Vets. Adm. Hosp. Clinical Records
 Address Fort Howard, Md.

17. Burial Date thereof July 27, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Angel Hill
 Location Havre de Grace, Md.

18. Funeral director Permynter & Son
 Address Havre de Grace, Md.

19. 7/1 86 A.W. Naduck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 46 at 1:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 46 to June 29 19 46

and that I last saw him alive on June 29 19 46

Immediate cause of death.....
Pulmonary Tuberculosis far ad-
vanced, active 4

DURATION

4 wks.
plus

Due to.....

Due to.....

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

R.E.M. Robert M. Cullison
ROBERT M. CULLISON, M.D., CLIN. DIR.

23. SIGNATURE..... M. D. or other

Address Fort Howard, Md.Date signed 6-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 133

CERTIFICATE OF DEATH

05681

Reg. Dist. No.

33

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills, Md (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs + 6 days
 Hospital, institution, or street address where death occurred:
Owings Mills, Md.
 How long in hospital or institution? 8 yrs + 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Carroll County Carroll
 City or town Brit, Md. (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Dorothy Barber

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W S

6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) 5 Oct. '28 5. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
17 8 9 _____ hrs. _____ min.9. Birthplace Carroll County
(Town, county, and state)10. Usual occupation Inmate, Rosewood State11. Industry or business Drawing School, Owings Mills, Md.12. Name Unknown13. Birthplace Unknown14. Maiden name Marie Barber15. Birthplace Carroll County16. Informant Institutional records, RosewoodAddress Wood, Owings Mills, Md17. Burial Date thereof June 17-46
(Burial, cremation, or removal) (Which?) (month) (day) (year)Cemetery or crematory RosewoodLocation Balto Co.18. Funeral director J. F. Elmer, SonsAddress Pinebluff, Md.19. 6-17 19 46 Dorothy B. Elmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 46, at 4:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 46, to June 15 19 46, and that I last saw her dead on 15 June 19 46Immediate cause of death Drowning. DURATION 15 min.

Due to _____

Due to _____

Other conditions None 18 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None.

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident. Date of 6-15-46Where did injury occur? Owings Mills, Balto. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Bath tub.

Means of Injury _____ Injured at work? _____

23. SIGNATURE D. D. Caples M. D. Exam.
M. D. or other _____Address Pinebluff, Md. Date signed 6-15-46

RECEIVED
JUN 21 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05682

Reg. Dist. No. 42

1. PLACE OF DEATH:

County... Baltimore
 City or town... Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

926 Leeds Ave

How long in hospital or institution?.....

3. (a) FULL NAME

Edith M. Beall

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Female W. Widow

6. (b) Name of husband or wife Late James W. Beall

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) April 9, 1874.

8. AGE: Years..... Months..... Days..... It less than one day..... hrs. min.

72 2 10

9. Birthplace..... (Town, county, and state)

md. Z/W.

10. Usual occupation.....

11. Industry or business.....

12. Name..... Rudolph's Watkins

13. Birthplace..... md.

14. Maiden name..... Eudolph's Telcaggett

15. Birthplace..... md.

16. Informant..... Mrs. Ethel Ireland

Address..... 926 Leeds Ave.

17. Burial..... Date thereof..... (month) (day) (year)

Cemetery or crematory..... Grey Hill

Location..... Lawell, md.

18. Funeral director..... Harry Z. Witke

Address..... 4101 Edmondson Ave

19. Date rec'd by registrar..... June 20 1946 Registrar..... Ger Kieffer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md. County..... Baltimore

City or town..... Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 926 Leeds Ave.
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 19/46..... 19..... at 8-15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 1946 to June 19 1946

and that I last saw him/her alive on June 19 1946

Immediate cause of death..... Toxemia

DURATION..... 1 yr

Due to..... Gynecoma Mena 6 yrs

Due to..... Cardio vascular disease 1 yr

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Ger M. Kieffer

Address..... 2470 Nash Blvd M. D. or other.....

Date signed..... June 20 1946

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH

U.S. DEPARTMENT OF HEALTH

RECEIVED
JUL 3 1946
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-4

CERTIFICATE OF DEATH

05683 44
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 134 Days

Hospital, institution, or street address where death occurred:

V. A. Hospital, Fort Howard, Md.

How long in hospital or institution? 134 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 251 Robert St.
(If rural, give LOCATION)

2.(a) If veteran, name war W.W. I

3. (a) FULL NAME

Ollie J. Bee

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of ~~husband~~ or wife Francis Bee

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1896

8. AGE:

Years 50

Months 4

Days 0

If less than one day

hrs. min.

9. Birthplace Avalon, Va.

(Town, county, and state)

10. Usual occupation Stevadore

11. Industry or business

12. Name Horace Bee

13. Birthplace Virginia

14. Maiden name Teaby Keve

15. Birthplace Virginia

16. Informant Clin.-Records, Vet. Administration

Address Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 6, 1946
(month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Staunton, Va.

18. Funeral director Mrs. Geo. Holland

Address 1631 Druid Hill Ave., Baltimore, Md.

19. 6/6 46
(Date rec'd by registrar)

A.W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1946, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21, 1946 to June 4, 1946

and that I last saw him alive on June 4, 1946

Immediate cause of death

Hydronephrosis; chronic pyelo-nephritis

DURATION

Unknown

Due to Huge mass of caseous mesenteric and paraortic lymph nodes causing obstruction of ureter

Due to Old Pulmonary Tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert M. Cullison
R.M. Cullison, M.D., Clinical Director

Address V.A. Fort Howard, Md. Date signed 6/4/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15/M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 N. Tyronne St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rodrigo Bonilla

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lucy E.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 15 1893

8. AGE:

Years

Months

Days

If less than one day

73

4

10

hrs.

min.

9. Birthplace

Spain
(Town, county, and state)

10. Usual occupation

Teacher

11. Industry or business

FATHER
MOTHER

12. Name

Francisco Bonilla

13. Birthplace

Spain

14. Maiden name

Angel

15. Birthplace

Spain

16. Informant

Francisco F. Bonilla

Address

200 N. Tyronne St.

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Data rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946 at 79 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 26 1946 to June 25 1946

and that I last saw him alive on

June 23 1946

Immediate cause of death

Coronary Thrombosis

DURATION

5 days

Due to

Coronary Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert W. Garis, M.D.
M. D. or other

Address

1014 St. Paul St.

Date signed

6/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

★ 05685 40
Reg. Dist. No.

I. PLACE OF DEATH:

County Balto
City or town Fullerton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Balto
City or town Fullerton Hill Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

H Walter Bork

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced IN MARRIED

6. (b) Name of husband or wife Estelade Bork

7. Birth date of deceased (mo., day, yr.) Aug 9, 1872 6. (c) If alive, give age years

8. AGE: 73 Years Months Days If less than one day .hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Retail Farmer

11. Industry or business

12. Name Henry Bork

13. Birthplace Germany

14. Maiden name Anney Blomman

15. Birthplace

16. Informant Mrs Wm Hovak

Address Fullerton Md.

17. Burial (Burial, cremation, or removal, which) Date thereof June 21, 46
(month) (day) (year)

Cemetery or crematory St Johns Church

Location Swamp Air

18. Funeral director Chas. E. Goss

Address Benson, Md.

19. 6/19/46 19 6/19/46
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 19 46 at 8:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 to June 9 19 46

and that I last saw him alive on June 18 19 46

Immediate cause of death Cerebral Hemorrhage

Other conditions Essential Hypertension

Other conditions Cardiac Decompensation

Other conditions 8 yrs

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Baldwin M. D. or other

Address Baldwin Date signed 6/19/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1872
74

RECEIVED
JUN 28 1946
BUREAU T.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 0568830
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 months, 4 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 9 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2214 Canary Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lillian Bostwick

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

separated

6.(b) Name of husband or wife

Frank Bostwick6.(c) If alive, give age 2 years

7. Birth date of

deceased (mo., day, yr.)

August 7, 1895

8. AGE:

Years

50

Months

10

Days

4

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Factory laborer

11. Industry or business

Packing houses

MOTHER

FATHER

12. Name

Lewis Bailey

13. Birthplace

?

14. Maiden name

Mary Hickey

15. Birthplace

?

16. Informant

Hospital records

Address

Catonsville-28, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6/15/46
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 15th 1946

(Registrar)

Harold Miller
deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 46 at 7:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 7 19 45 to June 11 19 46and that I last saw him alive on June 11 19 46

Immediate cause of death

Chronic myocarditis
due to, Luetic aortitis

DURATION

Indef.
Indef.

Due to

General paresis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Isadore Tuerk, M.D.

M. D. or other

Address

Catonsville-28, Md.Date signed 6-12-46

RECEIVED

JUN 15 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 882

CERTIFICATE OF DEATH

Reg. Dist. No. 05687388

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. West Joppa Road
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Sister Mary Madeleine (Frances G. Bowes)
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) November 6th., 1900
6. (c) If alive, give age 46 years

8. AGE: Years 45 Months 7 Days 14 If less than one day ##### min.

9. Birthplace Everett Massachusetts
(Town, county, and estate)
10. Usual occupation Religious

11. Industry or business Mission Helpers

FATHER 12. Name William F. Bowes

13. Birthplace Boston, Mass

MOTHER 14. Maiden name Agnes T. Roche

15. Birthplace South Boston, Mass

16. Informant Mission Helpers Records

Address W. Joppa Road, Towson Md.

17. Burial Date thereof June 22nd, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mission Helpers

Location W. Joppa Road

18. Funeral director George J. Ruth, Inc.

Address 1735 Harford Avenue

19. 6-21-46 Anthony J. ...
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20th., 1946 at 0400 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1946 to 20 June 1946
and that I last saw him alive on 19 June 1946

Immediate cause of death Cerebral hemorrhage
DURATION 1 wk.

Due to Hypertension in Second ym.

Due to None

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. ✓

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE R. D. ... M. D. or other

Address 42 ... Date signed 20 June 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

107 Melvin Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Melvin Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Carrie Augusta Boyle

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Frank Boyle

7. Birth date of deceased (mo., day, yr.) July 25, 1878
 6.(c) If alive, give age _____ years

8. AGE: Years 67 Months 10 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Thistle Balto. Co. Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name John D. Bailey
 13. Birthplace Baltimore Co. Md.

14. Maiden name Sarah Cook
 15. Birthplace Baltimore Co. Md.

16. Informant Mr. Albert Bailey
 Address 107 Melvin Ave. Catonsville

17. Burial Date thereof June 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's Cemetery
 Location Edlicott City, Md.

18. Funeral director Easton Sabis
 Address 608 Frederick Ave. Catonsville

19. June 13, 1946 Harry D. Miller
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1946 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sub 18 1946 to June 12 1946
 and that I last saw him alive on June 11 1946

Immediate cause of death Courney ThrombosisDue to Cerebral SclerosisDue to Cardio-Vascularlesion & Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Eliot W. Johnson M.D.

Address 3432 Frederick Ave. Date signed 6/12/46

DURATION
<u>1 day</u>
<u>2 yrs</u>
<u>6 yrs</u>

RECEIVED
JUN 15 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Granite
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Granite
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary F. Brown

3. (b) Social Security Number

4. Sex

F.

5. Color or race

B.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John M. Brown8. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

June 2, 1885

8. AGE:

Years

Months

Days

If less than one day

6108

hrs.

min.

9. Birthplace

MD.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

FATHER

12. Name

William Butler

13. Birthplace

MD.

MOTHER

14. Maiden name

Ann Bush

15. Birthplace

MD.

16. Informant

Regina Smallwood

Address

Granite, MD.

17.

Burial
(Burial, cremation, or removal; Which?)

Date thereof

6-13-46
(month) (day) (year)

Cemetery or crematory

St. Alphonsus

Location

Woodstock, MD.

18. Funeral director

C. Gary Wren

Address

Windsorville, MD.

19.

6/10/46
(Date rec'd by registrar)

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Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/10

19

46

at

1

P.

30

M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 1

19

46

to

6/10

19

46

19

46

19

46

and that I last saw her alive on

6/10

19

46

19

46

19

46

19

46

Immediate cause of death

Hypertensive Cardio-Vascular Disease

DURATION

5 yrs.

Due to

Due to

Other conditions

Diabetes2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest E. Buehler MD

MD or other

Address

Elliot City, MD

Date signed

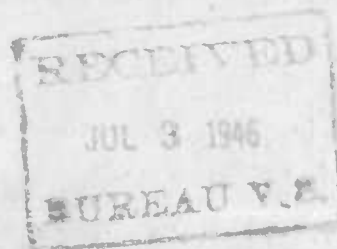
6/10/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05689



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05690

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Westminster Road
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Iola M. Burkett

3. (b) Social Security Number

220-12-6801

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or wife Leon C. Burkett

6. (c) If alive, give age years

T. Birth date of deceased (mo., day, yr.) Dec. 16, 1891

8. AGE:

Years

54

Months

5

Days

30

If less than one day

..... hrs. min.

B. Birthplace Balto. City
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden name Minnie Dashiels15. Birthplace Balto. City16. Informant Leon C. BurkettAddress Reisterstown, Md.17. Burial Date thereof June 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. LukesLocation Balto. Co.18. Funeral director J. F. Eline & SonsAddress Reisterstown, Md.19. 6-7 1946 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 19 46, at 8 p. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 28, 19 46, to June 5, 19 46.and that I last saw her alive on June 5, 19 46.

Immediate cause of death

Heart failure

DURATION

Due to Chron. Myocarditisseveral
years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. W. M. Landon M. D. or otherAddress Reisterstown, Md. Date signed 6/8/46

RECEIVED

JUN 11 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

05691

1. PLACE OF DEATH:

Coupy. Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 110 Clarendon Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

George Latimer Bussey

3. (b) Social Security Number

215-10-4622

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife La Rue Shipley
 7. Birth date of deceased (mo., day, yr.) Nov. 2-1885 6.(c) If alive give age 48 years

8. AGE: Years 60 Months 7 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Chapman, Maryland
 (Town, county, and state)

10. Usual occupation Nice Pres.

11. Industry or business Rehabe Legions Co.

12. Name Robert Harris Bussey

13. Birthplace Queenie F. Thomas

14. Maiden name La Rue Shipley Bussey

15. Birthplace 110 Clarendon Ave. Pikesville

16. Information Burial

Address 110 Clarendon Ave. Pikesville

17. Date thereof June 14-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Beth. National Cemetery

Location Fredrick Rd. Balto.-Md.

18. Funeral director Frank H. Murrell

Address Pikesville, Maryland

19. 6-14-46 19 46 Dr. E. E. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 46 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 46 to June 11 19 46

and that I last saw him alive on June 11 19 46

Immediate cause of death _____

Due to Angina Pectoris

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE John D. Robert

Address 1803 Park Heights Ave Date signed 6/11/46

M. D. or other _____

RECEIVED

JUN 18 1945

BUREAU 76

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05692

1. PLACE OF DEATH

County BaltimoreRegistration Dist. No. 7 57Village or City Timonium

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 17 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

William Herbert Butcher Sr(a) Residence: No. Timonium Md. St. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Florence May Butcher
June 14, 1946

6. DATE OF BIRTH (month, day, and year)

June 28, 1873

7. AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.721117

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Blacksmith

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Free

10. Date deceased last worked at this occupation (month and year)

June 1943

11. Total time (years) spent in this occupation

50

12. BIRTHPLACE (city or town) (State or country)

Balts Co Maryland

FATHER

13. NAME

Robert Butcher

14. BIRTHPLACE (city or town) (State or country)

York Co Penna

MOTHER

15. MAIDEN NAME

Elizabeth Gosnell

16. BIRTHPLACE (city or town) (State or country)

York Co Penna

17. INFORMANT

Florence May Butcher

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Poplar Grove Date June 14, 1946

19. UNDERTAKER

London M. Brooks

(Address)

Sparks, Md.

20. FILED

8-15 1946 Wilmer C. Ensor

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June 12, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

July, 1936, to June 12, 1946I last saw him alive on 10, 1946; death is saidto have occurred on the date stated above, at 4:30 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Coronary Occlusion 11 June 46

Other Contributory Causes of Importance:

Arterio-sclerosis 1943

Name of operation

None

Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles H. Veir M. D.(Address) 6701 York Rd Balts Co. Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1372)

CERTIFICATE OF DEATH

0569344
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war SAW ☒

3. (a) FULL NAME

ROBERT BUTLER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married8.(b) Name of husband or wife Mabel Butler

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 19 19788. AGE: Years 68 Months 1 Days 20 It less than one day hrs. min.9. Birthplace Floyd County, Va.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name MARSHAL BUTLER13. Birthplace VA.MOTHER 14. Maiden name ELIZABETH FOSTER15. Birthplace VA16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Md.17. BURIAL Date thereof 6-13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BALTIMORE NATIONALLocation BALTIMORE MD.18. Funeral director F.C. HIGINBOTHAMAddress ELICOTT CITY MD.19. 6-11-46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1946, at 6:30 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946 to June 9, 1946
and that I last saw him alive on June 9, 1946Immediate cause of death Dilatation & Hypertrophy of heart; pulmonary edema; lobular pneumonia DURATION Unknown

Due to

Due to

Other conditions Uremia associated with hypertrophy of prostate and urinary obstruction (Include pregnancy within 3 months of death) Unknown

Major findings of operations

Date of op.

Autopsy results Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CHIEF, M. D. DIRECTOR
Address Ft. Howard, Md. Date signed 6-9-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 05094

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 2613 Royal Oak Ave.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 2613 Royal Oak Ave.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

DAVID R. BYRNE

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

no

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary L. Byrne (nee Anthony)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1873

8. AGE: Years Months Days If less than one day

73

2

11

hr.

min.

9. Birthplace Kansas

(Town, county, and state)

10. Usual Occupation Butcher11. Industry or business Self12. Name John Thomas Byrne13. Birthplace Ireland14. Maiden Name Ryan15. Birthplace U. S. A.16 (a) Informant Mrs. Mary L. Byrne(b) Address 2613 Royal Oak Ave.17 (a) Burial (b) Date thereof 6/22/46

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.Location Woodlawn, Md.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.19 (a) JUN 20 1946

(Date of registration)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1946, at 7:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1946, to June 19, 1946, and that I last saw him alive on June 18, 1946.

Immediate cause of death

Myocarditis

Duration

2 yrsDue to Pneumonia, BronchitisDue to Sexuality

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide no
- (b) Date of occurrence — at — M
- (c) Where did injury occur?
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
- (e) Means of injury Charles J. Miller

23. Signature Charles J. Miller

Address 5276 Park Heights Date signed 6-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05695 43

1. PLACE OF DEATH:

County BaltimoreCity or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4910 Kenwood Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 5411 East Ave
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

Mamie C Byrne

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Wm P Byrne

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Oct 22 1894

8. AGE:

Years

Months

Days

If less than one day

5184

hrs.

min.

9. Birthplace Baltimore County Md(Town, county, and state)
At Home

10. Usual occupation

11. Industry or business

FATHER

12. Name

Charles Haug

13. Birthplace

Germany

MOTHER

14. Maiden name

Catherine Hammer

15. Birthplace

Germany

16. Informant

Mrs Geo. Diepold

Address

4910 Kenwood Ave17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 6/29/46

(month) (day) (year)

Cemetery or crematory

Perkwood

Location

Baltimore

18. Funeral director

Address

Lassahn Funeral Home
7401 Belair Road Balto 6 Md

19.

(Date rec'd by registrar)

19. 46Ans G. L. Repnider

Registrar

MEDICAL CERTIFICATION

June 26 1946

3:15 PM

20. DATE OF DEATH..... 19....., at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 5th19. 45to June 2619. 46and that I last saw h. or alive on June 26th, 19. 46

Immediate cause of death

Carcinoma of pelvic organs with metastases throughout abdomen.

DURATION

2 yrs.?

Due to

Primary in Cervix of uterus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Wilkinson
A. L. Wilkinson

M. D. or other

Address 5713 Bel Air Rd. Date signed 6/28-46

Dr. A. L. Wilkinson

RECEIVED

JUL 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

05696

30

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs., 9 mos., 4 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 5 yrs., 9 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1823 North Gay Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Peter H. Campbell

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced separated
 6.(b) Name of husband or wife Mary A. Connelly.
 6.(c) If alive, give age 63? years
 7. Birth date of deceased (mo., day, yr.) December 26, 1868
 8. AGE: Years 77 Months 5 Days 14 If less than one day
 hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation odd jobs.
 11. Industry or business miscellaneous
 12. Name John Campbell
 13. Birthplace Maryland
 14. Maiden name Martha ?
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland

17. Burial Date thereof 6-13-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lorraine Park
 Location Windsor Mill Road
Leob G. Cook

18. Funeral director Leob G. Cook
 Address 1701-03 N. Patterson Park Ave

19. 6-11-46 19 1946
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 46, at 7:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 5 19 40 to June 9 19 46
 and that I last saw him alive on June 9 19 46

Immediate cause of death Arteriosclerotic gangrene of the
left foot DURATION 9 days

Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Isadore Tuerk, M.D.
 M. D. or other

23. SIGNATURE Catonsville-28, Md. Date signed 6-9-46

Evidence for the change of
age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 153

05698

FILM No. I O 6 JUL 17 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County Balto.

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto

City or town Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 N. Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph James Cap.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 25/1930

8. AGE:

Years 15

Months 11/6

Days 7

It less than one day

hrs. min.

9. Birthplace

Balto Co Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

05697

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 DaysHospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.How long in hospital or institution? 32 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 935 Brunswick St.
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

3. (a) FULL NAME

FREDERICK J. CHRISTOPHER

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-1894

8. AGE:

Years

Months

Days

If less than one day

51611

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

MOTHER FATHER

12. Name

John C. Christopher

13. Birthplace

Germany

14. Maiden name

Frances Elson

15. Birthplace

Germany16. Informant Clinical Records, Vets. Adm. Hosp.

Address

Ft. Howard, Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof June 14 1946
(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Baltimore, Md.

18. Funeral director

A. Lee Oger

Address

4644 York Rd. Balto., Md.

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 19 46, at 9:10 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 10, 19 46, to June 11, 19 46and that I last saw him alive on June 11, 19 46

Immediate cause of death

Carcinoma of larynx

DURATION

Unknown

Due to

Due to

Other conditions Aspiration pneumonia1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Robert M. Collison
R. M. COLLISON, M.D. CLIN. M.D. or other

Address

Fort Howard, Md.Date signed 6-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05099

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balti.
 City or town Pleasant Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Balti.
 City or town Pleasant Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Joshua Clements
 4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced W.

3. (b) Social Security Number

none.

6. (b) Name of husband or wife

Rosa Hoffman

7. Birth date of deceased (mo., day, yr.) May 19, 1857. 8. (c) If alive, give age - years

8. AGE: Years 89 Months 1 Days 8 If less than one day - hrs. - min.

8. Birthplace Ellicott City Howard, Md.
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Joshua Clements
 13. Birthplace Don't know
 14. Maiden name Susan Bartlett
 15. Birthplace Don't know

16. Informant Mrs. Elmer Frank

Address Pleasant Hill

17. Burial Date thereof June 30, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Hill

Location Restertown Road

18. Funeral director Wm. Berryman & Sons

Address Restertown, Md.

19. June 28 19 46 Mary D. Sline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 19 46 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from several years 19 - to June 27, 1946 and that I last saw him alive on June 26, 1946

Immediate cause of death Stroke DURATION ?

Due to Stroke

Due to Stroke

Other conditions Stroke
 (Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE E. E. Nichols M.D. M. D. or other

Address Parkville Date signed 6-28-46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

FILE NO.

RECEIVED
JUL 1 1946
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05700

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
 How long in hospital or institution? 31 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 951 Etting St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I ★

3. (a) FULL NAME

HURLEY CONNOWAY

3. (b) Social Security Number

4. Sex Male	5. Color or race Colored	6. (a) Single, married, widowed, or divorced Single	
6. (b) Name of husband or wife <u>Single</u>			
7. Birth date of deceased (mo., day, yr.) <u>3-22-91</u>			
8. AGE:	Years	Months	Days
	<u>55</u>	<u>2</u>	<u>17</u>
6. (c) If alive, give age _____ years			
9. Birthplace <u>Berlin, Md.</u> (Town, county, and state)			
10. Usual occupation <u>Unemployed</u>			
11. Industry or business _____			
FATHER	12. Name <u>Tytus Connaway</u>		
	13. Birthplace <u>Maryland</u>		
MOTHER	14. Maiden name <u>? Selby</u>		
	15. Birthplace <u>Maryland</u>		

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Ft. Howard, Md.

17. Burial Date thereof 6 13 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Md.

18. Funeral director William A. Jackson
 Address 916 Pennington Baltimore - 1 - Md.

19. 6-14 19 46
 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 19 46 at 12:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 9, 19 46 to June 9, 19 46
 and that I last saw him alive on June 9, 19 46

Immediate cause of death
Far Advanced Active Pulmonary
Tuberculosis
 Due to Tubercle Bacillus

Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)
 Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Mode of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
 Address Ft. Howard, Md. Date signed 6-9-46

Registrar

05701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (472)

CERTIFICATE OF DEATH

Reg. Dist. No. *47*

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 128 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Maryland
 How long in hospital or institution? 128 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 26 N. Bond Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I ✓

3. (a) FULL NAME

HARRY COOK

3. (b) Social Security Number

218-10-3137

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife LILLIE COOK
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 1, 1889
 8. AGE: Years 57 Months 2 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Annapolis, Maryland
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name John Wesley Cook
 13. Birthplace Annapolis, Md.
 14. Maiden name Rebecca Johnson
 15. Birthplace Annapolis, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 6/29/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Int. Calvary
 Location _____

18. Funeral director Ethoy O. Wilson
 Address 1000 Brantley Ave

19. 6/26/46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 6:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 18 19 46 to June 26 19 46
 and that I last saw him alive on June 26 19 46

Immediate cause of death Bronchogenic carcinoma with
metastasis to the ribs DURATION Unknown

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. CLIM. D. Hooper
 Address Fort Howard, Md. Date signed 6-26-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05702 38
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

616 Woodbine Avenue

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Woodbine Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

EVANS CURRY CROW

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Josephine Yoder Crow
6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 19, 1898

8. AGE:	Years	Months	Days	If less than one day
<u>48</u>	<u>2</u>	<u>2</u>	<u>---</u>	hrs. min.

9. Birthplace Uniontown, Penna.
(Town, county, and state)

10. Usual occupation Farmer-Banker

11. Industry or business V.P. Production Credit Corp.

FATHER
12. Name William Evans Crow
13. Birthplace McClelland Town, Penna.

MOTHER
14. Maiden name Adelaide Curry
15. Birthplace Uniontown, Penna.

16. Informant William J. Crow
Address 127 N. Carrolltown Ave.,

17. Removal Uniontown, Penna.
(Burial, cremation, or removal. Which?) Date thereon June 22, 1946
Cemetery or crematory J.H. Johnson Funeral Home
Location Uniontown, Penna.

18. Funeral director John Burke's Sons
Address Towson, Maryland

19. June 22, 1946
(Date rec'd by registry) Registrar Wm. H. ...

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1946 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 June to time of death, and that I last saw him alive on 21 June 1946

Immediate cause of death Coronary Thrombosis

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert H. Allison M. D. or other

Address 4 Bursleigh Sq. Towson, Md. Date signed 22 June 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 3 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05703

38

Reg. Dist. No.

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Sheppard and Enoch Pratt Hospital</u> How long in hospital or institution? <u>Since May 24, 1946</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Towson 4. F.D. #6</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Harford Road above Joppa Road</u> (If rural, give LOCATION) <u>★</u> 2.(a) If veteran, name war <u>World War I</u>			
3. (a) FULL NAME <u>William Francis Crowe</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>				5. Color or race <u>White</u>			
6. (a) Name of husband or wife <u>Marguerite A. Crump</u>				6. (c) If alive, give age <u>53</u> years			
7. Birth date of deceased (mo., day, yr.) <u>April 10, 1892</u>				8. AGE: Years <u>54</u> Months <u>2</u> Days <u>1</u> If less than one day hrs. ____ min. ____			
9. Birthplace <u>Baltimore</u> (Town, county, and state)				10. Usual occupation <u>Automobile mechanic</u>			
11. Industry or business <u>Sheppard & Pratt</u>				12. Name <u>William J. Crowe</u>			
13. Birthplace <u>Ireland</u>				14. Maiden name <u>Rose O'Neill</u>			
15. Birthplace <u>Unknown</u>				16. Informant <u>Wife - Marguerite A. Crowe</u> Address <u>Towson 4, Maryland</u>			
17. Burial (Burial, cremation, or other) Which? <u>Burial</u> Date thereof <u>6 - - 46</u> (month) (day) (year) Cemetery or crematory <u>Parkwood</u> Location <u>Baltimore</u>				18. Funeral director <u>Leonard J. Ruck</u> Address <u>5305 Harford Road.</u> <u>6 - 22 46</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>June 11</u> 19 <u>46</u> , at <u>6 A</u> M							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 ____ to <u>June 11, 19 46</u> and that I last saw him alive on <u>June 11</u> 19 <u>46</u>							
Immediate cause of death <u>Acute cardiac decompensation</u>							
Due to <u>Aortic stenosis & mitral insufficiency</u>							
Due to <u>Probable old rheumatic carditis</u>							
Other conditions <u>Probable old rheumatic carditis</u>							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Autopsy results <u>corroborative</u>							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
23. SIGNATURE <u>Harry M. Murdock</u> <u>Harry M. Murdock, M.D.</u> M. D. or other Address <u>Towson 4, Md.</u> Date signed <u>6/11/46</u>							

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

05704

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ANNIE ELIZABETH DAY

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife William P. Day

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 18788. AGE: Years 68 Months 3 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Charlottesville Va.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Dorothy Morris13. Birthplace Charlottesville, Va.14. Maiden name Sarah Elizabeth Cranford15. Birthplace Proffitt Va.16. Informant Mrs. Eleanor ScarboroughAddress Stevenson, Md.17. Burial Date thereof June 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Melville Cem.Location Elkridge, Md.18. Funeral director Easton SonsAddress Edlicott City, Md.19. 6-4- 19 46 Dr. E. E. Nichols
(Data rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1946 at 2 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9, 1945 to June 4, 1946and that I last saw her alive on May 18, 1946

Immediate cause of death _____

DURATION

Cancer of the Breast 6 years

Due to _____

Due to _____

Other conditions Metastases of Brainand lungs. E

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis J. Ahnau1413 Piedmont M. D. or otherAddress Pikesville, Md. Date signed 6/4/46

RECEIVED
JUN 7 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Diat. No. 05705 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years, 4 months, 22 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 years, 4 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1232 Battery Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George Dellman

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Anna Mary Miller
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 6, 1862
 8. AGE: Years 84 Months 1 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Theodore Dellman13. Birthplace Germany14. Maiden name Hermine15. Birthplace Germany16. Informant Hospital recordsAddress Catonsville-28, Maryland

17. Burial Date thereof June 13, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium London ParkLocation Federicks Road

18. Funeral director John C. Moran
 Address 3000 Baltimore St

19. 6-12 - 1946 Harry J. Miller
 (Registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1946 at 12:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 19 1942 to June 10 1946

and that I last saw him alive on June 10 1946

Immediate cause of death Cerebral hemorrhage
 DURATION 28 hrs.

Due to Hypertensive arteriosclerotic heart disease
 Indef.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D.
 Address Catonsville-28, Md. M. D. or other _____

Date signed 6-10-46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 13 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH



Reg. Dist. No. 0570844

1. PLACE OF DEATH:

County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 910 D St.
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Sparrows Point Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 910 "D" Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Lucella K. Dolan

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Thomas E. Dolan

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1896

8. AGE: Years 49 Months 6 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Penna
(Town, county, and state)

10. Usual occupation _____

11. Industry or business Housewife

12. Name John Fox

13. Birthplace Md.

14. Maiden name Grace Boyle

15. Birthplace Pa.

16. Informant Thomas E. Dolan

Address 910 D St. Sparrows Point

17. Burial Date thereof June 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer Cem.

Location Belair Road

18. Funeral director John A. Moran

Address 3000 E. Balto. St.

19. June 15 - 1946 Dawson T. Harber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 - 1946 at 5:2 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 - 1946 to June 13 - 1946

and that I last saw her alive on June 12 - 1946

Immediate cause of death Cardiac Failure DURATION 2 weeks

Due to Arricular fibrillation 10 yrs

Due to and mitral stenosis

Due to Arterio-sclerotic

Other conditions heart disease

none

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Dawson T. Harber M. D. or other _____

Address Sparrows Point, Md. Date signed 6/15/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (448)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7 Stanley Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Catonsville
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Stanley Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Hugh R. Duncan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Olive Griffith Duncan

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Nov. 18, 1885.

8. AGE:

60

Years

6

Months

25

Days

It less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Police Office

11. Industry or business

FATHER

12. Name

Robert Duncan

13. Birthplace

Md.

MOTHER

14. Maiden name

Jane Rankin

15. Birthplace

Scotland

16. Informant

Mrs. Olive G. Duncan

Address

7 Stanley Drive

17.

(Burial, cremation, or removal. Which?)

Removal

Date thereof

June 13/46.

(month) (day) (year)

Cemetery or crematory

Allegheny Cemetery

Location

Frostburg, Md.

18. Funeral director

Harry F. Withke

Address

4101 Edmondson Ave.

19.

(Date rec'd by registrar)

June 13, 1946Harry F. Miller

Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1946. 19 46 at 3:30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 11 19 46 to June 13 19 46
and that I last saw him alive on June 13 19 46

Immediate cause of death Cerebral edema

secondary to a large tumor
(adenoma or melanotic carcinoma)

Due to and Hypertensive
arterio-sclerotic disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Grafton Harper

M.D. or other

Address

214 Medical Bldg BuildingDate signed 6/13/46

RECEIVED

JUN 15 1946

BUREAU

Reg. Dist. No.

Address VAH. Fort Howard, Maryland Date signed _____

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

05769

Reg. Dist. No. 57

1. PLACE OF DEATH:

County Baltimore
 City or town Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.5 years
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. York Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clara Knight Ewing

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

later Married

6.(b) Name of husband or wife

George A. Ewing

7. Birth date of deceased (mo., day, yr.)

Oct. 26, 1876

6.(c) If alive, give age

25 years

8. AGE:

Years

Months

Days

If less than one day

69825

hrs.

min.

9. Birthplace

Harford Co. Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Wm. H. Knight

13. Birthplace

Benn

14. Maiden name

Elizabeth Taylor

15. Birthplace

Harford Co., Md.

16. Informant

George A. Ewing

Address

Sparks, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 22, 1946
(month) (day) (year)

Cemetery or crematory

Gessops

Location

Sparks, Maryland

18. Funeral director

Landon M. Sparks

Address

Sparks, Md.

19.

June 21 1946

Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1946, at 2:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 18 1946, to June 20 1946.and that I last saw him alive on June 18 1946.

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to

Due to

Other conditions

Myocardial

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. M. France

M. D. or other

Address

Parkton, Md.

Date signed

6/20/46

RECEIVED

JUN 24 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on 2411 N. Charles St., Baltimore 742

FILM No. 104 JUL - 1 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BALTIMORE
City or town BENGIES MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
BARQUE ROAD
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 20 YRS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BALTO.
City or town BENGIES Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. BARQUE ROAD
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME

HERMAN A. EY

3. (b) Social Security Number

NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife MARY EY

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) MAY 28 1889

8. AGE: Years 59 Months 57 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual occupation TAXI CAB OWNER

11. Industry or business FOR SELF

12. Name FREDERICK EY

13. Birthplace GERMANY

14. Maiden name MARGARET CLEAR

15. Birthplace GERMANY

16. Informant MARGARET UNGLESBEE (SISTER)

Address 332 FRANKLINTOWN ROAD

17. BURIAL Date thereof JUNE 15/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory OAKLAWN

Location EASTERN AVE. EXT.

18. Funeral director Billy & Zeiler inc.

Address 403 S. WOLFE ST.

19. 6-14-46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH JUNE 12 19 46 at 7/30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/10 19 46, to 6/12 19 46
and that I last saw him alive on 6/11 19 46

Immediate cause of death

Cerebral stenosis as
Hy Coronary thrombosis
Hypertension
Arterio sclerosis
(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

1 day
2 yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Charles A. Calkins M.D. M. D. or other _____

Address 2145 N. Baltimore Date signed 6/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49)

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltoCity or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3009 Alabama Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)Street No. 3008 Alabama Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Helen Ferrari

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or

Silvio Ferrari

7. Birth date of deceased (mo., day, yr.)

Aug 7, 1883

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

62 10 8 hrs. min.

9. Birthplace

Italy
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At home

12. Name

Albert Barci

13. Birthplace

Italy

14. Maiden name

Emma Agudini

15. Birthplace

Italy

16. Informant

Mary Falconi

Address

3009 Alabama Ave

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

6/18/46
(month) (day) (year)

Cemetery or crematory

Cathedral

Location

Balto. Md.

18. Funeral director

William Cook Inc

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

6-18-46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1946 at 2:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 20, 1945 to June 15, 1946and that I last saw him alive on June 14, 1946

Immediate cause of death

Papillomatous carcinoma of thevulva with general metastases.

DURATION

1 yr.3 mos.

Due to

Due to

Other conditions Diabetes ?

(Include pregnancy within 3 months of death)

Major findings of operations As above.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry Deibel M.D.

M. D. or other

Address 1226 Hanover St. Date signed 6/15/46

STATE OF MARYLAND—CERTIFICATE OF DEATH

712

1. PLACE OF DEATH

County Balto.

Village or City Essex

Registration Dist. No. 41

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S. If of foreign birth?

Yrs.

Mos.

Ds.

2. FULL NAME

(a) Residence: No. 1 N. Belmont

(Usual place of abode)

St.

Word

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Peter

1882

6. DATE OF BIRTH (month, day, and year)

May 29/1872

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

16

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

Zmgorod, Poland

FATHER

13. NAME

Peter Jendryczak

14. BIRTHPLACE (city or town) (State or country)

Poland

MOTHER

15. MAIDEN NAME

Victoria ?

16. BIRTHPLACE (city or town) (State or country)

Poland

17. INFORMANT

(Address)

Edna Koraleski

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Rosary Date 6/9/46

19. UNDERTAKER

(Address)

John M. Peter
401 G. B. Lester St.

20. FILED

6/15/46

19

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

(Year)

June 16, 1946

22.

I HEREBY CERTIFY, That I attended deceased from

, 19

, to

, 19

I last saw h. alive on

, 19

; death is said

to have occurred on the date stated above, at 1:45 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion

Date of onset

Immediate

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

Dr. J. M. Baran
Dept. Medical Science
Baltimore, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927
Other contributory causes of importance:	
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago
Other contributory causes of importance:	
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4/

1. PLACE OF DEATH:

County Baltimore
 City or town Baltimore 22, Dundalk
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 145
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore 22, Dundalk
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 699 Arundel Rd. South
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Anne Elizabeth Barrett, Anne Elizabeth

3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Elmer Barrett
 6.(c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) Jan. 25, 1884
 8. AGE: Years 62 Months 6 Days 11 If less than one day
 hrs. min.

9. Birthplace Baltimore Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Ellison Sawann

13. Birthplace Howard County, Maryland

14. Maiden name ?

15. Birthplace ?

16. Informant Elmer Barrett

Address 699 Arundel Rd. South Baltimore 22, Md.

17. Burial Date thereof 7/3/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Peters
 Location Baltimore, Md.

18. Funeral director Charles G. Cooper
 Address 510-512 Carrollton Ave

19. 2/2 46 A-W Hedrick
 (Date rec'd by registrar) 19. 20 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1946 at 10 28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1946 to June 29, 1946

and that I last saw her alive on June 29, 1946

Immediate cause of death Bronchial Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE William S. Wade M.D.
 M. D. or other

Address 140 Oak Ave Date signed 6-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05714

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
Baltimore County Home
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Opportunity Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Stanley Gatherright

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male col. Single

8. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1878

8. AGE: Years Months Days If less than one day
67 9 26 _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER 12. Name Charles Gatherright

13. Birthplace Virginia

14. Maiden name Anna ?

15. Birthplace Virginia

16. Informant Baltimore County Welfare Board

Address Towson Maryland

17. Burial Date thereof June 27, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto. Co. Home Cem.

Location Texas Md.

18. Funeral director London Brooks

Address Sparkie, Md.

19. June 26, 1946 Wm J. Bahilewicz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 27 19 46 to June 26 19 46
and that I last saw him alive on 6/25 - 19 46

Immediate cause of death Coronary Thrombosis DURATION 1 day

Due to Arterio Sclerosis

Due to _____

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Evers M.D. M. D. proctor
Address Cockeysville Md Date signed 6/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01720

STANDARD TELETYPE

RECEIVED
JUL 3 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 0571541

1. PLACE OF DEATH:

County BaltimoreCity or town Inverness
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Monyhs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Inverness
(If outside city or town limits, write RURAL and give nearest town)Street No. 19 Winona Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William S. Getshall Jr.

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Margaret E. Getshall6.(c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) July 19, 1891

8. AGE: Years Months Days If less than one day

541111

.....hrs.min.

9. Birthplace Kent County, Md.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name William S. Getshall Sr.13. Birthplace Kent County, Md.14. Maiden name Anna Travis15. Birthplace Kent County Md.16. Informant Margaret E. GetshallAddress 19 Winona Ave17. Burial Date thereof July 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Baltimore, Md.18. Funeral director Frederick A. HopeAddress 1700 W. Lombard St19. 7-3 Registrar 85

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946 at 19 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19

Immediate cause of death

myocarditis, acuteDuration six monthsDue to bronchial pneumonia, two months previously

Due to

Other conditions ParsunsonsUlcer
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry GilbertAddress 7 Beech Dr.M. D. or other 5/3/46

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Baltimore County
City or town Halethorpe, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Years
Hospital, institution, or street address where death occurred:
5635 Ashbourne Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Halethorpe, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5635 Ashbourne Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Francis E. Goodrich
3. (b) Social Security Number 216-05-5503

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Olivia F. Goodrich
6. (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) March 8, 1903
8. AGE: Years 43 Months 2 Days 24 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Investigator
11. Industry or business Small Loan Co.
FATHER 12. Name Adelbert L. Goodrich
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Sarah C. Cleaver
15. Birthplace Baltimore, Md.

18. Informant Olivia F. Goodrich
Address 5635 Ashbourne Rd.

17. Burial June 27 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.
18. Funeral director John R. Kenny
Address 1242 Leeds Terrace-Arbutus, Md.

19. 6-26-46 19 46 Dr. Goodrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 19 46, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/20/46 to 6/24 19 46
and that I last saw him alive on 6/24/46 19 46

Immediate cause of death Hypoxia Pneumonia
Due to Emphysema
Due to Cerebral Hemorrhage
Other conditions

DURATION

2 days9 days4 days

(Include pregnancy within 3 months of death)

Major findings of operations
Autopsy results None
Date of op.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ch White MD M. D. or other
Address 1279 Guilman Date signed 6/25/46

Dr. C. B. Whittle L. 1490

1279 Williams St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Reisterstown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Abraham Greider

3. (b) Social Security Number

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Lilly Greider (nee Curtis)7. Birth date of deceased (mo., day, yr.) Jan 26, 1865

6.(c) If alive, give age..... years

8. AGE: Years 81 Months 4 Days 9 If less than one day..... hrs. min.9. Birthplace Lancaster, Pa.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Abraham Greider13. Birthplace Lancaster, Pa.14. Maiden name Annie Mesher15. Birthplace Lancaster, Pa.16. Informant Mrs. Richard EganAddress 106 Reisterstown Road17. Burial Burial Date thereof 6-7-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wood Ridge CemeteryLocation Pikesville, Md18. Funeral director Loring MyersAddress 5005 Park Heights Ave19. 6/7 19 46 A. W. He duck
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 46 at 1:25 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 19 46 to June 3 19 46 and that I last saw him alive on June 3-46 19Immediate cause of death Coronary ThrombosisDURATION 2 dayDue to Arterio Sclerosis

Due to

Other conditions Bronchial Pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Samuel Plummer

M. D. or other

Address 5611 Pimlico RdDate signed 6-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Four days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? Four days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5611 35th Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Jane Groh

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife - - - -
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 5, 1929
 8. AGE: Years 16 Months 11 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Brooklyn, N.Y.
 (Town, county, and state)
 10. Usual occupation Student
 11. Industry or business None
 12. Name John Groh
 13. Birthplace Brooklyn, N.Y.
 14. Maiden name Mildred Pearson
 15. Birthplace Brooklyn, N.Y.

16. Informant Hospital records, Spring Grove State
 Address Hospital, Catonsville, 28, Md.

17. Burial Date thereof June 19, 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hyattsville
 Location Hyattsville Md

18. Funeral director Harroch Sons
 Address Hyattsville, Md.

19. 6-17 19 46 Harry Miller
 Registrar Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1946 19 _____ at 9:15 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946 19 _____ to June 16 19 46and that I last saw him or her alive on June 16, 1946 19 _____Immediate cause of death Acute encephalitis
type undeterminedDURATION
16 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Henry C. A. Mead, M.D.Address Catonsville, 28, Md. Date signed 6/16/46

RECEIVED
JUN 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

C5719

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Towson R.D. (Baynesville)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

8723 Loch Bend Drive

How long in hospital or institution?

3. (a) FULL NAME

William Hamer4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Annie ~~Hattie~~ Milne Hamer7. Birth date of deceased (mo., day, yr.) July 18, 19888. AGE: Years 57 Months 10 Days 26 If less than one day — hrs. — min.9. Birthplace Halifax, England
(Town, county, and state)10. Usual occupation Supervisor11. Industry or business Western Electric Co.12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. David DoughertyAddress W. Chesapeake Ave., Towson, Md.17. Cremation Date thereof June 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmount CemeteryLocation Baltimore, Maryland18. Funeral director John Burnie JonesAddress Towson, Md.19. June 17 19 46 awed nsk
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson R.D. (Baynesville)
(If outside city or town limits, write RURAL and give nearest town)Street No. 8723 Loch Bend Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 13, 1946 to June 13, 1946and that I last saw him alive on June 13, 1946Immediate cause of death Heart disease, coronary artery with coronary occlusion DURATION 6/13/46Due to Heart disease, chronic myocarditis, unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rollin B. Huber M.D. DME.Address Towson 4, Md. Date signed 6/13/46

RECEIVED BY THE POSTAL SERVICE AT THE POST OFFICE OF THE DISTRICT OF COLUMBIA, D. C. MAY 10 1964

Mr. Sedlacek

CENTRAL INTELLIGENCE AGENCY

RECEIVED BY THE POSTAL SERVICE AT THE POST OFFICE OF THE DISTRICT OF COLUMBIA, D. C. MAY 10 1964

100-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05720
Reg. Diat. No. 31

1. PLACE OF DEATH:

County Harrisonville
 City or town Balto.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto
 City or town White Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Harrisonville
 (If rural, give LOCATION)
 2(a) If veteran, name was

3. (a) FULL NAME

Louisa Handley Hanley

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Michael Hanley

7. Birth date of deceased (mo., day, yr.)

Dec. 2 - 1855

6. (c) If alive, give age.....years

8. AGE:

Years

80

Months

6

Days

7

If less than one day

.....hrs.min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

John Henry Bankstall

13. Birthplace

Germany

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Wm. Hanley

Address

Harrisonville, Maryland

17. Burial

Burial
(Burial, cremation, or removal. Which?)

Date thereof

June 11 - 46
(month) (day) (year)

Cemetery or crematory

Holy Family

Location

Harrisonville, Md.

16. Funeral director

Frank H. Newell

Address

Pikesville, Maryland

19.

6/9/46
(Date rec'd by registrar)19. 46Tom E. Martin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9 - 1946, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12 to June 9, 1946
and that I last saw him alive on June 9, 1946

Immediate cause of death

Cardiovascular Disease

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

Tom E. Martin
Address Pikesville, Md. Date signed 6/9/46

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

RECEIVED
JUL 3 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

0572130
Reg. Dist. No.

1. PLACE OF DEATH: **Baltimore**
County.....
City or town..... **Catonsville**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **1 year, 3 months, 30 days**
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? **1 year, 3 months, 30 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **Maryland** County..... **Harford**
City or town..... **Havre de Grace**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **5009 Franklin St.**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Howard Hartzell

3.(b) Social Security Number

4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **divorced**
8.(b) Name of husband or wife..... **Mary Reed**
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) **March 5, 1884**
8. AGE: Years **62** Months **3** Days **1** If less than one day
.....hrs.min.

9. Birthplace..... **Norristown, Pennsylvania**
(Town, county, and state)
10. Usual occupation..... **meat cutter**
11. Industry or business **butcher**
12. Name..... **Abraham Hartzell**
13. Birthplace..... **Pennsylvania**
14. Maiden name..... **Ida Seasholtz**
15. Birthplace..... **Pennsylvania**

16. Informant..... **Hospital Records**
Address..... **Catonsville 28, Md.**
17. **Removal** Date thereof **6-7-46**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... **Riverside Cemetery**
Norristown, Pa.
18. Funeral director..... **W.G. Tichner & Son**
Address..... **Norristown - Penn. Ave.**
19. **June 7th** 19 **46** **Harry D. Miller**
..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **June 6** 19 **46** at **9:20 p.**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 7 19 **45** to **June 6** 19 **46**
and that I last saw him alive on **June 6** 19 **46**

Immediate cause of death..... **Coronary Thrombosis**
DURATION **3 months**

Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
Autopsy results..... **no**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE..... **Isadore Tuerk**
Catonsville 28, Md. M. D. or other
Address..... Date signed..... **6/7/46**

13509

DEPT. OF JUSTICE - CIVIL DIVISION

WASHINGTON, D. C. 20535



ATTESTED

CLERK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

05722

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Life
 Hospital, institution, or street address where death occurred:
De Vere Lane
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. De Vere Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Dr. Franklin Hazlehurst

3.(b) Social Security Number

4. Sex... male
 5. Color or race... white
 6.(a) Single, married, widowed, or divorced... married

6.(b) Name of husband or wife... Hannah Niemeyer

6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) December 27, 1882

8. AGE: Years... 63 Months... 5 Days... 27
 If less than one day... hrs. min.

9. Birthplace... Baltimore, Md.
(Town, county, and state)10. Usual occupation... Physician

11. Industry or business.....

12. Name... Franklin Hazlehurst13. Birthplace... Baltimore, Md.14. Maiden name... Mary Norris15. Birthplace... Baltimore, Md.16. Informant... Mrs. Hannah N. HazlehurstAddress... DeVere Lane, Catonsville, Md.

17. Burial... Date thereof... 6/26/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium... Druid RidgeLocation... Pikesville, Md.18. Funeral director... John O. Mitchell & Sons, Inc.Address... 1900 Eutaw Place, Baltimore, Md.

19. June 25 19 46
 (Date rec'd by registrar) Registrar Harrell Miller

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 23 1946 at... 5:40 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
April 1 1946 to 6-22 1946
 and that I last saw him alive on June 23 1946

Immediate cause of death.....

DURATION

ANGINA PECTORIS 1-2 YEAR
 Due to... CORONARY SCLEROSIS 1-2

Due to... 0Other conditions... 0

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results... 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of.....Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury 0 Injured at work?23. SIGNATURE... S. Lloyd Johnson M. D. or otherAddress... 610 Frederick Rd. Date signed... 6-25-46Catonsville, Md.

RECEIVED
JUN 26 1946
BUREAU V.S.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05723

Reg. Dist. No.

44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 54 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a.a.c.
City or town East Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2815 4th Avenue
(If rural, give LOCATION)
World War I ★
2.(a) If veteran, name war

3. (a) FULL NAME

JOHN F. HERBERT

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mrs. Minnie Herbert
7. Birth date of deceased (mo., day, yr.) February 24, 1898 8. (c) If alive, give age 47 years
8. AGE: Years 48 Months 4 Days 2 If less than one day
.....hrs.min.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1946, 12:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 1946 to June 26, 1946
and that I last saw him alive on June 26, 1946
Immediate cause of death Coronary Occlusion, acute DURATION sudden
Due to.....
Due to.....
Other conditions Broncho-pleural fistula 25 Days
Due to Empyema, chronic, left Unknown
(Include pregnancy within 3 months of death)

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation Lumber Scaler
11. Industry or business
FATHER 12. Name Frank Herbert
13. Birthplace Baltimore, Maryland
MOTHER 14. Maiden name Unknown
15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial Date thereof 6/29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Balto. National
Location Frederick Rd. Balto - 3rd
18. Funeral director Silly + Ziller, Chas.
Address 403 S. Wolfe Street
19. 6/27 19 46 A.W. Hedrick
(Date rec'd by registrar) Registrar

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically 48
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIR. or other
Address Fort Howard, Md. Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (932)

Registered No. 05724

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 5310 Overhill Ave.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto. Co.
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 5310 Overhill Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Ida Rosella Hillary

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

F.

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife William H. Hillary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1868

8. AGE: Years 77 Months 11 Days 3 If less than one day hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

12. Name John Williams

13. Birthplace Baltimore, Md.

14. Maiden Name Susan Harrison

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Quinton R. Hillary

(b) Address 5310 Overhill Ave.

17 (a) Burial (b) Date thereof June 21, 1946

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn P.O. Balto. Md.

18 (a) Funeral director Frederick V. Foley

(b) Address 1200 N. Lombard St.

19 (a) b-18-46 (b) (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1946, at 2 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1946 to June 18th 1946 and that I last saw him alive on June 17th 1946.

Immediate cause of death cerebral hemorrhage

Duration

6 days

Due to generalized arteriosclerosis with hypertension.

Due to

Other Conditions Hypertensive heart disease with hypertrophy.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Nichol

Address 2901 Edison Ave Date signed June 19th 1946

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 55-6

Reg. Dist. No.

CERTIFICATE OF DEATH

15725

1. PLACE OF DEATH

(a) County Baltimore
 (b) City or town Crofton
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution: 6013 Hazelwood Ave
 (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
 (e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State md (b) County _____
 (c) City or town _____
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 6013 Hazelwood Ave
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Joseph Adam Hiltz

3 (b) If veteran, name war

3 (c) Social Security

No. 218-01-6455

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Marie Hiltz

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

June 20th 1901

8. AGE:

Years

Months

Days

If less than one day

44

hr.

min.

9. Birthplace

md
 (Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name

Frank Hiltz

13. Birthplace

md

14. Maiden Name

Mary Wick

15. Birthplace

md

16 (a) Informant

Mrs. Marie Hiltz

(b) Address

6013 Hazelwood Ave

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

June 4th 1946
 (month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Road

18 (a) Funeral director

Leo S. Leach

(b) Address

1701-02 N. Patterson Park Ave

19 (a)

6-3-46
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death June 1 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to June 1 1946, and that I last saw him alive on June 1 1946.

Immediate cause of death

Poisoning

Due to

Intoxication with morphine

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

6 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
 (Specify type of place)

(e) Means of injury _____

23. Signature

Dr. M. Baumgardner
 M. D. or other

Address

Baltimore Md

Date signed 5-1-46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. If of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than
1 day, ----- hrs.
or ----- min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BDDKKEEPER, etc.9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)

13. NAME

14. BIRTHPLACE (city or town)
(State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town)
(State or country)

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER

(Address)

20. FILED

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

1936 (Year)

22. I HEREBY CERTIFY, That I attended deceased from

19

to

19

I last saw him alive on

19

to have occurred on the date stated above, at ----- m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Date of onset

Accidental drowning
Body found 9/9/46.
Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide

Date of Injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

M. D.

(Address)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., *heart failure, asphyxia, asthenia*, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05727

Reg. Dist. No. 44

1. PLACE OF DEATH.

County BaltimoreCity or town Dundalk - 22
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one year

Hospital, institution, or street address where death occurred:

7000 Mornington RoadHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Dundalk - 22
(If outside city or town limits, write RURAL and give nearest town)Street No. 7300 Dunwall Court

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Bessie Elizabeth Hopkins

3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Clarence Russell Hopkins7. Birth date of deceased (mo., day, yr.) 29 October 18956. (c) If alive, give age 51 years8. AGE: Years 50 Months 7 Days 9 If less than one day
..... hrs. min.9. Birthplace Marian-Somerset Co. - Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles Somers13. Birthplace Somerset Co. - Maryland14. Maiden name Sarah Tull15. Birthplace Somerset Co. - Maryland16. Informant Clarence Russell HopkinsAddress 7300 Dunwall Court17. Burial Date thereof 6/10/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Eastern Ave. Rd.18. Funeral director John D. ConnellyAddress 418 Eastern Ave. Essex 419. June 9 1946 - John D. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 June 1946 at 10:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
30 May 1946 to 7 June 1946and that I last saw her alive on 7 June 1946Immediate cause of death Cardiac failure

DURATION

24 hr.Due to Bronchial asthma 3 years.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bernard W. Sallad, M.D.
M. D. or otherAddress 8 Liberty Parkway Date signed 7 June 1946

MASTLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE DEPARTMENT OF HEALTH

REGISTERED

RECEIVED

JUN 11 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05728 P.

1. PLACE OF DEATH:

County Fort Howard, Md.City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.How long in hospital or institution? 62 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 732 N. Spring St.

(If rural, give LOCATION)

2. (a) If veteran, name war World War I ★ 1 ✓

3. (a) FULL NAME

LEE A. JORDAN

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Wid.

6. (b) Name of husband or wife

Wid.

7. Birth date of

deceased (mo., day, yr.)

February 26, 1892

6. (c) If alive, give age. years

8. AGE:

Years

54

Months

3

Days

4

If less than one day

hrs. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER

12. Name

William Jordan

13. Birthplace

North Carolina

MOTHER

14. Maiden name

Mary ?

15. Birthplace

Virginia

16. Informant

Clinical Records, Vets. Adm. Hos.

Address

Fort Howard, Maryland

17.

Burial

Date thereof

7-3-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Baltimore National Cem.

Location

Baltimore, Maryland

18. Funeral director

Charles E. Law

Address

802 Madison Ave.

19.

7-2-46

19.

HeLee Jordan

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 46, at 10:24A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 3019 46to June 3019 46and that I last saw him alive on June 30 19 46Immediate cause of death HEART DISEASE -
CORONARY ARTERIOSCLEROSIS WITH
MYOCARDIAL INSUFFICIENCY

DURATION

10 mos.

Due to

Due to

Other conditions GANGRENE OF LEFT THIGH
DUE TO OCCLUSION OF LEFT FEMORAL
ARTERY (Include pregnancy within 3 months of death)1 monthMajor findings of operations Amputation left legDate of op. 6-19-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert M. Allison
R. M. CULLISON, M.D. CLIN. DIR
Fort Howard, Md.

Address

Date signed 6-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County... *Baltimore*
 City or town... *Owings Mills*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *25 yrs 11 mo*
 Hospital, institution, or street address where death occurred:
Rosewood State Training School
 How long in hospital or institution? *25 yrs 11 mo*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... *Md* County... *Baltimore*
 City or town... *Woodlawn*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war... *no*

3. (a) FULL NAME

Arthur Leroy Kauffman

3. (b) Social Security Number

4. Sex... *male* 5. Color or race... *white* 6. (a) Single, married, widowed, or divorced... *Single*
 6. (b) Name of husband or wife...
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... *Oct 3, 1910*
 8. AGE: Years... *35* Months... *8* Days... *24* It less than one day... hrs. min.

9. Birthplace... *Woodlawn, Balto Co., Md*
 (Town, county, and state)
 10. Usual occupation... *Inmate; Rosewood State Training School; Owings Mills, Md*
 11. Industry or business... *School; Owings Mills, Md*
 12. Name... *Edward Kauffman*
 13. Birthplace... *Pennsylvania*
 14. Maiden name... *Leona Ross*
 15. Birthplace... *Virginia*

16. Informant... *Institutional Records; Rosewood State Training School; Owings Mills, Md*
 Address...
 17. *Burial* Date thereof... *6 29 46*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... *Rosewood Cemetery*
 Location... *Balto Co. Md.*
Lincoln Funeral Home

18. Funeral director...
 Address... *7401 Belair Rd*

19. *July 3* 19 *46* *Mary B. Elms*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *June 27* 19 *46* at *2:40 P. M.*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 22* 19 *46* to *June 27* 19 *46*
 and that I last saw him alive on *June 27* 19 *46*
 Immediate cause of death...
Lobar Pneumonia DURATION... *6 days*
 Due to...
 Due to...
 Other conditions... *Mongolism* *Congen.*
 (Include pregnancy within 3 months of death)
 Major findings of operations... *none* Date of op... *none*
 Autopsy results... *none*
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? *none*
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... *George C. Medairy M. D.*
 Address... *Owings Mills, Md* Date signed... *6/27/46*

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 6 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05730

Reg. Dist. No. 3a

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **1 yrs., 1 month, 5 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **1 yrs., 1 month, 5 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **247 South Highland Avenue**
 (If rural, give LOCATION)
 2.(c) If veteran, name war.....

3.(a) FULL NAME

Julia Kimble

3.(b) Social Security Number

4. Sex..... **female**
 5. Color or race..... **white**
 6.(a) Single, married, widowed, or divorced..... **single**
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **1889?**
 8. AGE: Years..... **57** Months..... **?** Days..... If less than one day..... hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **None**
 11. Industry or business..... **None**
 12. Name..... **Herman Kimble**
 13. Birthplace..... **Pittsburgh, Penna.**
 14. Maiden name..... **Rosalie ?**
 15. Birthplace..... **Pittsburgh, Penna.**

16. Informant..... **Hospital records**
 Address..... **Catonsville-28, Md.**

17. Burial..... **Burial** Date thereof..... **July 19, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Spring Grove State Hospital**
 Location..... **Catonsville 28, Maryland**

18. Funeral director..... **Spring Grove State Hospital**
 Address..... **Catonsville 28, Maryland**

19. **7-19-** 19. **46** Registrar.....
 (to be filled by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **June 9** 19. **46** at **9:50 p** M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 4 19. **45** to **June 9** 19. **46**
 and that I last saw her alive on **June 9** 19. **46**

Immediate cause of death.....
Peritonitis
 DURATION..... **2 days**
 Due to **Volvulus obstruction of the** Indef.
descending colon at junction of the
 Due to **sigmoid involving entire descending**
colon from the splenic flexure. Indef.
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... **Showed obstruction of the**
intestinal tract, fluid in Date of op. **6-8-46**
As above. abdomen.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **Isadore Tuerk, M.D.** M. D. or other
 Address..... **Catonsville-28, Md.** Date signed..... **6-10-46**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 22 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 103

CERTIFICATE OF DEATH

05731

Reg. Dist. No. 30

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>7 months 15 days</u> Hospital, institution, or street address where death occurred: <u>Spring Grove State Hospital</u> How long in hospital or institution? <u>7 months 15 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1301 Linden Street</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Louis Kirchheiner</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Separated</u>			
6. (b) Name of husband or wife <u>Blanche Tzaid</u>							
7. Birth date of deceased (mo., day, yr.) <u>February 28, 1876</u>							
6. (c) If alive, give age years							
8. AGE: Years <u>70</u>		Months <u>3</u>		Days <u>11</u>		If less than one day hrs. min.	
9. Birthplace <u>New York N.Y.</u> (Town, county, and state)							
10. Usual occupation <u>Coppersmith</u>							
11. Industry or business <u>Metallurgy</u>							
FATHER							
12. Name <u>Louis Kirchheiner</u>							
13. Birthplace <u>Germany</u>							
MOTHER							
14. Maiden name <u>Louisa Voigt</u>							
15. Birthplace <u>New York</u>							
16. Informant <u>Hospital Records, Spring Grove Hospital</u> Address <u>Catonsville, 28, Md.</u>							
17. BURNED <u>BURIAL</u> Date thereof <u>6/11/46</u> (Burial, cremation, or other, Which?) (month) (day) (year) Cemetery or crematory <u>OAK LAWN CEM.</u> Location <u>7225 EASTERN AV.</u> <u>JOHN R. KENNY</u>							
18. Funeral director <u>JOHN R. KENNY</u> Address <u>1242 LEEDS TER. ARBUTHNOT-MD</u> #27							
19. 6-10-46 Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>June 8, 1946</u> 19..... at <u>4:00 P.M.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Oct. 23 1945</u> 19..... to <u>June 8 1946</u> 19..... and that I last saw him alive on <u>June 8, 1946</u> 19..... Immediate cause of death <u>Terminal right lower lobar pneumonia</u>							
Due to <u>Generalized arteriosclerosis</u> <u>cachexia</u> Due to <u>Hypertensive C-V-R Disease</u> Other conditions (Include pregnancy within 8 months of death) Major findings of operations Date of op.							
DURATION <u>5 days</u> Indef							
Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>Henry C. A. Mead, M.D.</u> Address <u>Catonsville, 28, Md</u> Date signed <u>6/8/46</u>							

①

HONORABLE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93)

05732

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5313 Edmondson Ave - Hood Nursing Home

How long in hospital or institution?

18 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1442 Riverside Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie M. Kessel

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced WidowedB. (b) Name of husband or wife Edward C. Kessel7. Birth date of deceased (mo., day, yr.) Och 29 - 1857 8. (c) If alive, give age 88 years8. AGE: Years 88 Months 7 Days 2 If less than one day hrs. min.9. Birthplace Baltimore Md
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name John Riedel13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Alroy RiedelAddress 1533 Northgate Road17. Burial Date thereof June 4, 1946
(Burial, cremation, or removal - Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Taylor Ave18. Funeral director Mrs. John W. Gensel & SonAddress 801 W. Fayette St. Balto. Md19. 6-3 46 Harvey H. Miller
(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1946 at 3-45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 1 1946and that I last saw her alive on May 31 1946Immediate cause of death Arterio Sclerosis withChr MyocarditisDUE TO 1 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gene H. H. H. H. M. D. or otherAddress Baltimore Date signed 6/1

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

★ 05733 41
Reg. Dist. No.

1. PLACE OF DEATH: **Baltimore**
County.....
Dundalk
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
14 Flagship Road
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **Md.**..... County..... **Baltimore**
City or town..... **Dundalk**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **14 Flagship Road**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Marie K. Knecht

3. (b) Social Security Number

4. Sex **female** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **widow**
6.(b) Name of husband or wife **Jacob Knecht**
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) **October 8, 1868**
8. AGE: Years **77** Months **8** Days **2** If less than one day
..... hrs. min.

9. Birthplace..... **Germany**
(Town, county, and state)
10. Usual occupation..... **none**
11. Industry or business.....

12. Name **Michael**
13. Birthplace.....
14. Maiden name..... **Marie**
15. Birthplace.....

16. Informant..... **Mrs Alexander Mc Gowan**
Address..... **14 Flagship Road, Dundalk**

17. **Burial** Date thereof **June 13, 1946**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... **Oaklawn**
Eastern Avenue
Location.....

18. Funeral director..... **Roland L. Fisher**
Address..... **2112 Dundalk Avenue**

19. **6/13/46** 19.....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **June 10,** 19..... **46** at **8:50 P** M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 19..... **44** to **June 10,** 19..... **46**
and that I last saw h..... alive on **June 10,** 19..... **46**

Immediate cause of death.....
myocarditis, acute
arteriosclerosis.
Due to.....
Due to.....

Other conditions..... **Cerebral hemorrhage**
(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE..... **David H. Andrew M.D.**
Address..... **2 Kensington Rd Dundalk Md.** M. D. or other
Date signed..... **6/12/46**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1946

BUREAU V. 8

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 05734

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 44
 Village or City Bachman Neck Road No. Route 13 Box 199 St. 20 Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Ludmila Krizan
 (a) Residence: No. Route 13 Box 199 St. _____ Ward _____
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Frank Krizan</u>		
6. DATE OF BIRTH (month, day, end year) <u>Sept 16, 1881</u>		
7. AGE Years <u>64</u> Months <u>8</u> Days <u>25</u> If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. _____	
10. Date deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____	

12. BIRTHPLACE (city or town) (State or country) Czestochowa - Hungary

13. NAME Stephen Krizan

14. BIRTHPLACE (city or town) (State or country) Czestochowa - Hungary

15. MAIDEN NAME Not Known

16. BIRTHPLACE (city or town) (State or country) Czestochowa - Hungary

17. INFORMANT Mary Honza

(Address) Bachman Neck Road

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer Date 6-13-46, 19

19. UNDERTAKER Frank Grackson

(Address) 900 N. Chestnut St.

20. FILED June 10, 1946

John D. Smully
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June 10, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 5, 1946, to June 10, 1946

I last saw him alive on June 10, 1946; death is said to have occurred on the date stated above, at 5 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Cerebral ganglione

Date of onset

June 5/46

Other Contributory Causes of Importance:

Arterio-sclerotic Cardiovascular disease

Name of operation _____

Date of _____

What test confirmed diagnosis? _____

Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) M. J. Smully

M. D.

(Address) Baltimore

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

Reg. Dist. No. 44

05735

1. PLACE OF DEATH:

County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mos

Hospital, institution, or street address where death occurred:

22 Murray Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. 52 Murray Drive
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

George F. Laird Sr.

3. (b) Social Security Number

150-09-7500

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Wife

7. Birth date of deceased (mo., day, yr.)

Dec 7, 18858. (c) If alive, give age 54 years

8. AGE:

60 Years 6 Months 19 Days If less than one day

9. Birthplace

Philadelphia Pa.
(Town, county, and state)

10. Usual occupation

Tool Grinder

11. Industry or business

Personal Land

12. Name

Philadelphia Pa.

13. Birthplace

Alma Calahan

14. Maiden name

Scotland

15. Birthplace

George F. Laird Jr.

16. Informant

4 Smith Ave.

17. Burial

Burial Date thereof July 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

18. Cemetery or crematory

Longview Cem.

19. Location

Philadelphia Pa.

20. Funeral director

Martin R. E. Offelstons

21. Address

7110 Belair Road

22. Date rec'd by registrar

June 26 1946 John V. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1946, at 2 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to June 26 1946 and that I last saw him alive on June 26 1946.

Immediate cause of death

Coronary Insufficiency

DURATION

Due to

Due to

Other conditions

Carcinoma of Lung
(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---

Means of injury

Injured at work?

23. SIGNATURE

JR Esteb M.D. M. D. or other
Address 7110 Belair Rd Balto 21 Date signed 6-26-46

RECEIVED

JUL 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

CERTIFICATE OF DEATH

05736

Reg. Dist. No. *36*

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, 1 mo., 29 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 2 years 1 month 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 670 West Fayette Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

FANNIE LAMONDE

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Albert W. Lamonde
 7. Birth date of deceased (mo., day, yr.) May 14, 1866 6. (c) If alive, give age _____ years
 8. AGE: Years 80 Months 1 Days 0 (If less than one day _____ hrs. _____ min.)

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Teacher
 11. Industry or business Education
 12. Name David George Beckwith
 13. Birthplace New York
 14. Maiden name Marie Egerton
 15. Birthplace Co. Fernanagh, Ireland.

16. Informant Hospital Records, Spring Grove State
 Address Hospital, Catonsville, 28, Md.

17. Burial Date thereof 6/18/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greenmount Cem.
 Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
 Address Balto., Md.

19. 6-17 19 46
 (by registrar) Registrar *Wm. J. Tickner*

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1946 19 _____, at 12:15A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1944 19 _____ to June 14, 1946
 and that I last saw her alive on June 14, 1946 19 _____
 Immediate cause of death Terminal pneumonia

DURATION

2 days

Due to Chronic myocardial insufficiency Indef.

Due to Arteriosclerotic C-V disease "

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Henry C. A. Mead, M.D.
Henry C. A. Mead, M.D. D. or other _____
 Address Catonsville, 28, Md. Date signed 6/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County Cotonsville
 City or town Cotonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Epit Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Ind. County Balto.
 City or town Cotonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Johnnyaske Rd + Gregory Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Maria A. Larabee

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife late Albert Larabee

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1864 6. (c) If alive, give age..... years

8. AGE: Years 81 Months 9 Days 6 If less than one day..... hrs. min.

9. Birthplace Elmira, N. Y.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Joshua Harrocks

13. Birthplace England

14. Maiden name Thanna Wood

15. Birthplace England

16. Informant Mrs. Belvie Langley

Address Cotonsville, Ind.

17. Removal Date thereof July 1, 1946.
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Forrest Hill Cemetery

Location Utica, N. Y.

19. Funeral director Harry H. Ruithe

Address 4101 E Almondson Ave.

19. 7-1 46 Aug 1946
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1946, to June 30 1946

and that I last saw her alive on June 30 1946

Immediate cause of death Cerebral Hemorrhage

Due to Advanced arteria sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallen, MD
 M. D. or other

Address Cotonsville-28, Ind Date signed 7-1-46

Mr. W. H. Gallagher
429 Huron Lane

29th Nov 1904
J. H. C. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05738 39

1. PLACE OF DEATH:

County BaltimoreCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

7705 Park Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. 7705 Park Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ELIZABETH S. LEASE

3. (b) Social Security Number

**

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Thomas F. Lease

7. Birth date of

deceased (mo., day, yr.)

October 11th, 1857

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8888

hrs.

min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name --- Silvers13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Charles J. LeaseAddress 7705 Park Drive, Parkville 14, Md.17. burial Date thereof June 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Balto., Md.18. Funeral director Louise Funeral HomeAddress 7401 Bel Air Road19. 6/20 (Date rec'd by registrar)19. 46A. M. Bacon
Regist.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th, 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3rd, 1946 to June 19th, 1946and that I last saw her alive on June 19th, 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

3 daysDue to Arteriosclerosis and hyper
tension

many yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Wilkinson
A. L. Wilkinson,

M. D. or other

Address 5713 Bel Air Rd. Date signed 6/20/46

RECEIVED

RECEIVED

RECEIVED

JUN 21 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05739

Reg. Dist. No. 44

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21 June

1946, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 June 1946, to 21 June 1946,

and that I last saw her alive on 21 June 1946.

Immediate cause of death

Decompensation

DURATION

1 hour

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 27 June 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4172 Park Ave

RECEIVED
JUL 1 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-7-M)

CERTIFICATE OF DEATH

Reg. Dist. No. 05740

1. PLACE OF DEATH:

County BaltimoreCity or town Butler
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Butler
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Eleanor Morgan Long

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Bertram Long7. Birth date of deceased (mo., day, yr.) April 6 1894 6. (c) If alive, give age _____ years8. AGE: Years 52 Months 2 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Dr. James D. Morgan13. Birthplace Charles Co Md14. Maiden name Mary Abell15. Birthplace Balto. Co.16. Informant Mr. G. Bernard FenwickAddress Glyndon Md17. Removal June 17 1946

(Burial, cremation, or removal Which?) _____ Date thereof _____ (month) (day) (year)

Cemetery or crematory Rock CreekLocation Washington D.C.18. Funeral director Henry W. Jenkins & Sons CoAddress McCulloch Orchard St19. 6/15 46 Awedrich

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1946 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-14 1946 to 6-14 1946 and that I last saw her dead on 6-14 1946Immediate cause of death Carbon monoxide Poisoning DURATION 7 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Extrick Date of 6-13-46Where did injury occur? Reisterstown Balto Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home - garage

Means of injury _____ Injured at work? _____

23. SIGNATURE D. D. Caples, M.D. Exam. med.Address Reisterstown Md Date signed 6-14-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd
VS
6/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 05741

Reg. Diat. No.

57

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Dora Price Matthews

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

Harry A. Matthews

7. Birth date of

deceased (mo., day, yr.)

Mar. 15, 1870

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7633

..... hrs. min.

9. Birthplace.....

Sparks, Maryland
(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

FATHER
MOTHER

12. Name.....

Wm. Henry Price

13. Birthplace.....

Sparks, Md.

14. Maiden name.....

Emma Matthews

15. Birthplace.....

Sparks, Md.

16. Informant.....

W. Matthews

Address.....

Sparks, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

June 20, 1946
(month) (day) (year)

Cemetery or crematory.....

Friends

Location.....

Sparks, Md.

18. Funeral director.....

Sanford M. Brooks

Address.....

Sparks, Md.June 19 46Wilmer C. Ensor

19. (Date rec'd by registrar).....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Baltimore

City or town.....

Sparks (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Quaker Station Road
(If rural, give LOCATION)

2. (a) If veteran, name War.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 1819. 46at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1219. 46

to

June 18, 1946

and that I last saw him/her alive on

June 1819. 46

Immediate cause of death.....

CORONARY THROMBOSIS

DURATION

3 days

Due to.....

Due to.....

Other conditions.....

CHRONIC MYOCARDITIS
HYPERTENSIV
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

R. W. France

M. D. or other

Address.....

Partham, Md. Date signed 6/19/46

14750

RECEIVED
JUN 22 1946
BUREAU V.B.

RECEIVED
JUN 22 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05742



Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 months, 23 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 9 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town R.F.D. #1, Hydes
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Elizabeth Susan McClary

3. (b) Social Security Number

-

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

f

w

widowed

6.(b) Name of husband or wife Walter J. McClary

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Aug 29-1876

8. AGE:

Years 69Months 9

Days

If less than one day

hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation housewife11. Industry or business home

FATHER MOTHER

12. Name ? Johnson13. Birthplace Maryland14. Maiden name ?15. Birthplace ?16. Informant Hospital Records
Address Catonsville 28, Md.17. Burial Date thereof June 10-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prospect HillLocation Rowson18. Funeral director Charles E. ArthurAddress FOR Mr.19. 6/11 19 46 Harry D. Miller
(Registrar) (Deputy Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 46 at 9:50 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 19 45 to June 7 19 46and that I last saw her alive on June 7 19 46

Immediate cause of death

Chronic Myocarditis

DURATION

1 monthDue to Arteriosclerotic Cardiovascular cerebral disease.

Indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

Isadore Tuerk23. SIGNATURE Catonsville 28, Md. M. D. or otherAddress _____ Date signed 6/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1946

BUREAU V.S.

Permanently
ARTERIAL LOGGER

NO CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

05743

CERTIFICATE OF DEATH

Reg. Dist. No.

FILM No. 106 AUG 13 1946

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore 22
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr 8 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 5201 Delmar Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Annie Winfield Miller

3. (b) Social Security Number

4. Sex

F

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 27, 1880

6. (c) If alive, give age years

8. AGE

Years 65Months 10Days 27

If less than one day

hrs. min.

9. Birthplace Prindel County, Maryland
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name Irish Winfield13. Birthplace Atlanta, Georgia14. Maiden name Rodis Brodgen15. Birthplace Prindel County, Maryland16. Informant Charles E. SimmsAddress 1015 Brontly Ave17. Burial Date thereof June 30, 1946
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory Arbutus MemorialLocation Mrs Kate R Williams18. Funeral director Mrs Kate R WilliamsAddress 322 N Schroeder St19. June 29 46 A. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

A E A

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 46 at 4:10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 46 to June 27 19 46and that I last saw h. alive on June 27 19 46Immediate cause of death Bronchial Pneumonia

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured of home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William P. O'Neil, M.D. M. D. or otherAddress 140 Oak Ave Date signed 6-27-46

STATE OF MARYLAND—CERTIFICATE OF DEATH

05744

P

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 142
 Village or City Middle River No. 1 St. Plant Ward 1
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. 507 E. 28th St. _____ Ward. _____
 (Usual place of abode)

If nonresident give city or town and State ✓

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5a. If married, widowed, or divorced HUSBAND or <u>WIFE of</u> <u>Catherine Miller</u>		
6. DATE OF BIRTH (month, day, and year) <u>Oct 2/1881</u>		
7. AGE Years <u>64</u>	Months <u>8</u>	Days <u>19</u> If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Machinist</u>		ff. Total time (years) spent in this occupation
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Glenn L. Martin & Co</u>		
10. Data deceased last worked at this occupation (month and year)		

12. BIRTHPLACE (city or town) Balto Md
 (State or country)

FATHER
 f3. NAME John Miller
 f4. BIRTHPLACE (city or town) Unknown
 (State or country)

MOTHER
 f5. MAIÖEN NAME Katherine
 f6. BIRTHPLACE (city or town) "
 (State or country)

17. INFORMANT Mrs Catherine Miller
 (Address) 507 E. 28th St.

f8. BURIAL, CREMATION, OR REMOVAL
 Place London Park Date 6/25, 1946

f9. UNDERTAKER William J. ...
 (Address) 1314 ...

20. FILED 6/24, 1946 R. W. Hedlund
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June 21, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 21, 1946 to _____, 19____.

I last saw h_____ alive on _____, 19____; death is said to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Coronary occlusion
 Date of onset 10 min.

Other Contributory Causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county and State)
 Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) D. M. ... M. D.
 (Address) Deputy Medical Examiner
Dundalk Md.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

Reg. Dist. No. 0574592

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs. 8 mos. 8 days
 Hospital, institution, or street address where death occurred:
Rosewood State School 1 (Owings Mills)
 How long in hospital or institution? 6 yrs 8 mos 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Brentwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4216 Prospect Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Mary Anne Miller (Mary Anne Miller)

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 12, 1935

8. AGE:

Years

Months

Days

If less than one day

10101

hrs.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Teacher

11. Industry or business

FATHER

12. Name

Robert T. Miller

13. Birthplace

Oakland, Md.

MOTHER

14. Maiden name

Leona Statkus

15. Birthplace

Baltimore Maryland

16. Informant

Rosewood State Training School

Address

Owings Mills, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 15-1946

Cemetery or crematory

Fort Lincoln

Location

Colmar Manor, Md.

18. Funeral director

Frank H. Newell

Address

Pikesville, Md.

19.

6-14-19 46

(Date rec'd by registrar)

Dr. E. E. NicholsMD

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13, 1946 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1, 1938 to June 13, 1946and that I last saw him alive on June 13, 1946

Immediate cause of death

BranchopneumoniaDue to BranchitisDue to Measles (Rubeola)Other conditions Chronic suppurative

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Isabel H. McClinton, M.D.Address Rosewood-Owings Mills, Md.Date signed June 13, 1946

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

RECEIVED

JUN 18 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05746

Reg. Dist. No. 42

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(c) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

married

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

June 16-1893

8. AGE:

Years

Months

Days

If less than one day

52

11

20

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 6 1946 at 1:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May - 30 1946 to June - 6 1946

and that I last saw him alive on

June 6 1946

Immediate cause of death.....

Endocarditis a

chronic myocarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings at operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 6/7/46

STATE OF MARYLAND—CERTIFICATE OF DEATH

05747

1. PLACE OF DEATH

County Balto Registration Dist. No. 41
 Village or City Dundalk No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 6 yrs. _____ mos. _____ ds. How long in U.S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. 16 Liberty Pkwy St. _____ Ward _____
 (Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>HARRIET S. MINNICK</u>		
6. DATE OF BIRTH (month, day, and year) <u>July 19/1882</u>		
7. AGE <u>64</u>	Years Months Days	If LESS than 1 day _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Blue Keeper</u>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Bark Strip Co.</u>		
10. Date deceased last worked at this occupation (month and year)		

12. BIRTHPLACE (city or town) Baltimore
 (State or country)

13. NAME Joseph J. Minnick
 14. BIRTHPLACE (city or town) Baltimore
 (State or country) Maryland

15. MAIDEN NAME Elizabeth Thomas
 16. BIRTHPLACE (city or town) Long Island
 (State or country) New York

17. INFORMANT HARRIET S. MINNICK
 (Address) 16 Liberty Parkway

18. BURIAL, CREMATION, OR REMOVAL
 Place Baltimore Date 6-18-1946

19. UNDERTAKER Chas. F. Evans & Son
 (Address) 118 W. THE ROYAL AVE

20. FILED 6/17/46 19 1946
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June 15, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 15/46, to _____, 19____

I last saw him _____ alive on _____, 19____; death is said to have occurred on the date stated above, at 12:15 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion

Other Contributory Causes of Importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) J. Minnick M. D.
 (Address) Dept. Medical Examiner

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927
Other contributory causes of importance:	
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago
Other contributory causes of importance:	
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

05748

1. PLACE OF DEATH

County Baltimore
 City or town Towson Mt. Dulaney Rd.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Dulaney Rd. 1.1 mile north of Towson.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town MONKTON
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Simon H Mondell

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jane St. Clair Mondell

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

4-27-1896

8. AGE:

Years

Months

Days

If less than one day

50

hrs.

min.

9. Birthplace

BILIZER, Russia
(Town, county, and state)

10. Usual occupation

Laundry + Cleaner

11. Industry or business

MOTHER

FATHER

12. Name

Harry -

13. Birthplace

Russia

14. Maiden name

Rose -

15. Birthplace

Russia

16. Informant

Jane St. Clair Mondell

Address

Monkton, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-9-46
(month) (day) (year)

Cemetery or crematory

Rosedale

Location

18. Funeral director

Address

Face Lewis Inc
1439 E. Balt. St

19.

(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 8, 1946, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____

Immediate cause of death

Compound fracturesskull, jaw and cervical spine.

DURATION

6/8/46.

Due to

Auto accident6/8/46

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

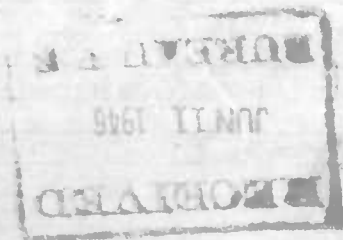
Accident, suicide, or homicide _____ Date of _____ 6/8/46Where did injury occur? Towson Baltimore Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway; Dulaney Rd.Means of injury Auto accident - no one injured at work? Yes

23. SIGNATURE

Rollin B. Hudson M.D. D.M.F.
M. D. or other _____

Address

Towson MdDate signed 6/8/46.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0574938
Reg. Dist. No.

1. PLACE OF DEATH

County BaltimoreCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yearsHospital, institution, or street address where death occurred:
Grindon Ave. at Rosehill Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. Grindon Ave. at Rosehill Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edward Jackson Monroe

3. (b) Social Security Number

213-20-5371

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single6.(b) Name of husband or wife --6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) May 14th, 19128. AGE: Years 34 Months 1 Days 14 If less than one day
.....hrs.min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Garbage Collector

11. Industry or business

12. Name Thomas A. Monroe13. Birthplace Va.14. Maiden name Betty R. Bryant15. Birthplace Va.16. Informant Mrs. Thomas A. MonroeAddress Grindon Ave., Parkville, Md.17. Hol Burial removal Date thereof July 1, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Balto., Md.18. Funeral director Local Funeral HomeAddress 7401 Belair Road19. 6/29 19 46 A.M. Bocow
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 46 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19 to 19 and that I last saw him None alive on 19

Immediate cause of death

Tuberculosis, pulmonary, advanced

DURATION

1 year

Due to

Due to

Other conditions Mental disorder, type not known 3 yrs +Inmate Sybilville 1944
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bollin C. Hudson M.D.Address Towson Md Date signed 6/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 2 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B38)

CERTIFICATE OF DEATH

Reg. Diat. No. 0575038

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since July 6, 1945
 Hospital, institution, or street address where death occurred
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since July 6, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County City Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4223 W. Annapolis Ave
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war

3. (a) FULL NAME

Boris Elizabeth Moore

3. (b) Social Security Number

220-03-6337

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Malvin Moore
 6. (c) If alive, give age 27 years
 7. Birth date of deceased (mo., day, yr.) March 30 1919

8. AGE: Years 27 Months 3 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name John Patrick Mc Laughlin

13. Birthplace Baltimore, Md

14. Maiden name Boris Krauske

15. Birthplace Baltimore, Md

Personal History- Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.

17. Buried Date thereof July 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer Ch

Location Belair Road

18. Funeral director John C. Moran

Address 3000 E Baltimore St

19. 7-1 19. Y.C. Christopher
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1946 at 12:35-p M

21. I CERTIFY that death occurred on the date stated; that I attended deceased from July 6 1945 to June 28 1946

and that I last saw him alive on June 28 1946

Immediate cause of death _____

Pulmonary tuberculosis Since January 1945

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W.A. Bridges M. D. or other

Address Towson 4, Maryland Date signed 6-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31

CERTIFICATE OF DEATH

05751

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years, 4 months, 11 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 8 years, 4 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Frank Anderson (Naughton)

3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 15, 1906
 8. AGE: Years 39 Months 10 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Coketon, West Virginia
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Railroad
 12. Name Fred (Joseph) Naughton
 13. Birthplace ?
 14. Maiden name Rose E. Paxton
 15. Birthplace ?

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof July 19, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Grove State Hospital
Catonsville 28, Maryland
 Location _____
 18. Funeral director Spring Grove State Hospital
 Address Catonsville 28, Maryland
 19. 7-19 19 46 Harry D. Miller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 46 at 12:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 6 19 38 to June 17 19 46
 and that I last saw him alive on June 17 19 46

Immediate cause of death _____ DURATION _____
Chronic myocarditis with acute ex-
 Due to acerbation indefinite
 Due to Cachexia, undetermined "
origin.
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results As above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
 Address Catonsville-28, Md. Date signed 7/4/46

RECEIVED

JUL 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05752

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Bundick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6809 Dundalk Road 9 yrs

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 6809 Dundalk Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Andy. P. Nelson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ethel Nelson6. (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) May 10 18848. AGE: Years 62 Months 0 Days 0 If less than one day

.....hrs.min.

9. Birthplace Fowler Indiana
(Town, county, and state)10. Usual occupation Steel Worker11. Industry or business Boatmen Steel12. Name Andrew M. Nelson13. Birthplace Denmark14. Maiden name Johanna Erickson15. Birthplace Denmark16. Informant Ethel NelsonAddress 6809 Dundalk Road17. Burial Date thereof June 4-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Rural18. Funeral director Wellschlag Funeral HomeAddress 2008 Orleans St19. 6/3 86 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 46 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 44 to June 1 19 46and that I last saw him alive on May 29 19 46Immediate cause of death Myocarditis, acute.Cerebral hemorrhageDue to Arteriosclerosis.Due to Hypertension.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David N. Andrew M.D.Address 2 Kingship Rd Dundalk Md M. D. or otherDate signed 6/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98d

CERTIFICATE OF DEATH

05753

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 11 mos. 26 days
 Hospital, institution, or street address where death occurred:
Spring Creek State Hosp.
 How long in hospital or institution? 1 yr. 11 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD. County... Baltimore
 City or town... Rural - Baltimore 28
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1607 Ridge Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Steele Nelson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife May Backley
 7. Birth date of deceased (mo., day, yr.) March 27, 1865 6.(c) If alive, give age _____ years
 8. AGE: Years 81 Months 2 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Gloucester, Mass.
 (Town, county, and state)
 10. Usual occupation Electrical Engineer } Retired
 11. Industry or business Unknown
 12. Name Christen Nelson
 13. Birthplace Copenhagen, Denmark
 14. Maiden name Jane Burpee
 15. Birthplace Portland, Me.

16. Informant Spring Creek State Hosp.
 Address Records

17. Burial Date thereof June 9/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gloucester, Mass.
 Location John O. Mitchell Sons

18. Funeral director 1900 Canton Plaza
 Address 6-9-46

19. 6-9-46 by registrar Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1946, at 3:45 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1944 to June 9, 1946
 and that I last saw him alive on June 9, 1946
 Immediate cause of death Chronic Myocarditis
 Due to Hypertensive Cardiac
Vascular Disease
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____

DURATION

12-14
12-14

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____
Gunshot Frank, M.D.
 23. SIGNATURE Spring Creek State Hosp. D. or other _____
 Address Catonsville, Md. Date signed June 9, 1946

RECEIVED

JUN 12 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05754

33

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville, Ind.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State Penna. County FranklinCity or town Fayetteville
(If outside city or town limits, write RURAL and give nearest town)Street No. Lincoln Highway, P. R. #1
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Mary Jeanne Nicklas

3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Reginald Nicklas6. (c) If alive, give age 31 years7. Birth date of deceased (mo., day, yr.) Sept 15 - 19188. AGE: Years 27 Months 10 Days 4 If less than one day
..... hrs. min.9. Birthplace Chambersburg Pa.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Robert D. Reummel13. Birthplace Franklin Co. Pa.14. Maiden name Dorothy Shaffer15. Birthplace Chambersburg Pa.16. Informant Reginald NicklasAddress P. R. #1 Fayetteville PaBurial June 23, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Chambersburg CemeteryLocation Chambersburg Pa.18. Funeral director Frank H. SpurrellAddress Pikesville, Maryland19. June 18, 1946 Mary B. Elmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1946, at 2 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-18-46 to 6-18-46 and that I last saw her alive not seen alive

Immediate cause of death	DURATION
Fractured skull (Occipital)	5 min.
Communitated fractures of both scapula	5 min.
Crushed ribs rt. & left (posterior)	5 min.
Internal Hemorrhage	5 min.
Abrasions of both shoulder & back	5 min.
Lacerated scalp	5 min.
(Include pregnancy within 8 months of death)	

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-18-46

Where did injury occur? Reisterstown Rd., Delight
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Motor accident Injured at work?

23. SIGNATURE D. D. Caples, M.D. Exam.
M. D. or other

Address Reisterstown, Md. Date signed 6-18-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 21 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05755

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore CountyCity or town Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

307 E. Joppa Road

How long in hospital or institution?

3. (a) FULL NAME

Grover Cleveland Orth

3. (b) Social Security Number

216-07-0096

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Hannah A. Orth6. (c) If alive, give age 51 years

7. Birth date of

deceased (mo., day, yr.) September 18, 1885

8. AGE:

60

Years

Months

8

Days

23

If less than one day

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Auditor

11. Industry or business

FATHER 12. Name George A. Orth13. Birthplace ?MOTHER 14. Maiden name Mary L. Overbeck15. Birthplace ?16. Informant Mrs. Hannah A. OrthAddress 307 E. Joppa Road, Towson, Md.17. Burial June 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore CemeteryLocation East End North Avenue18. Funeral director Howard A. GillAddress 19 W. Penna. Ave. Towson, Md.19. June 12 19 46
(Date rec'd by registrar) Registrar [Signature]

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 307 E. Joppa Road
(If rural, give LOCATION)

2. (c) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 46 at 3:25 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mon. 19 46 to June 10 19 46and that I last saw him alive on June 9 19 46Immediate cause of death Central Hemorrhage
(Apoplexy) Rt. SideDURATION
3 daysDue to General Arterio SclerosisDue to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel L. Ho. J. J. J.Address Towson, Md. Date signed 6/11/46

RECEIVED
JUL 3 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

05758

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Balto. Co.
 City or town..... W. Elliott City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Annie Oscar

7. Birth date of

deceased (mo., day, yr.)

March 2, 1875

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

7132

..... hrs.

..... min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Self12. Name..... Andred Oscar

13. Birthplace

Germany

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

George Dietz

Address

W. Chester Ave

17.

(Burial, cremation or removal, where?)

Date thereof

Burial 7/1/46
(month) (day) (year)

Cemetery or crematory

Mt. Olive

Location

Roslyn Balto. Co. Md.

18. Funeral director

William Cook Inc

Address

1217 St. Paul St.19. June 29, 1946

(Date rec'd by registrar)

A. W. HeyrichA. E. C.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... BaltoCity or town..... Wood lawn

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7200 Windsor Hill Rd

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 28th 19..... 46..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 19..... 46, to..... June 28 19..... 46and that I last saw him alive on..... June 27 19..... 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 days

Due to

ArteriosclerosisMyocardial

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE.....

A. C. Smith M. D. or otherAddress..... 4509 Liberty Hgts Date signed..... June 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:

County Balt.
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred: Home

How long in hospital or institution?

3. (a) FULL NAME

Edward Boetler Passano

3. (b) Social Security Number

- ? -

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Eleanor Phillips Passano6. (c) If alive, give age 74 years

7. Birth date of

deceased (mo., day, yr.)

Aug. 11, 1872

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>10</u>	<u>2</u>	hrs. min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual occupation

President

11. Industry or business

Waverly Press

FATHER

12. Name Louis Loderbin Passano

13. Birthplace

Md.

MOTHER

14. Maiden name Alice Fletcher Wagnuder

15. Birthplace

Md.

16. Informant

Mr. Edward M. Passano

Address

3925 Linkwood Rd. Balt. Md.

17. Burial

(Burial, cremation, or removal, which?)

BurialDate thereof 6-15-46
(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

Pikesville, Md.

18. Funeral director

STEWART & MOWEN COMPANY

Address

(W. F. WOODEN BLDG.) 100 N. NORTH AVENUE19. June 15

Date rec'd by registrar

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

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Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

19. 46

Date

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balt.

City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Susquehanna Av.
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 13th 19 46 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 23 19 40 to June 13 19 46

and that I last saw him alive on June 13 19 46

Immediate cause of death

Coronary Thrombosis

DURATION

24 Hrs.

Due to

Due to

Other conditions

(1940)
Arterio-sclerotic Cardio Vascular Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Anthony J. Thomas M.D.Address 400 York Rd M. D. or otherDate signed 6/14/46

RECEIVED
JUL 3 1946
BUREAU V S

STATE OF MARYLAND—CERTIFICATE OF DEATH

P

1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S. If of foreign birth?

Yrs.

Mos.

Ds.

Registration Dist. No.

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

St.,

Ward

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

St.,

Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, hrs. of min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

13. NAME

14. BIRTHPLACE (city or town) (State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER

(Address)

20. FILED

6/15/46

Registral

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY That I attended deceased from

June 13, 1946, to June 13, 1946.

I last saw h. alive on 19. death is said

to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Electrocution by live wire 550 volts.

Other Contributory Causes of importance:

3rd degree burns at chest & arm & leg.

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide Accident Date of injury 6/13, 1946

Where did injury occur? Sparrows Point Md.

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury By Electric wire.

Nature of injury Contact with wire.

24. Was disease or injury in any way related to occupation of deceased? Yes.

If so, specify

(Signed)

M. D.

(Address) Deputy Medical Examiner

If more blanks are needed, address State Registrar, 241 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Rec'd YS
8/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *74a*

05759

CERTIFICATE OF DEATH

Reg. Dist. No. *30*

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years, 15 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 15 years, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6 West 25th Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas J. Philbin

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 4, 1879
 8. AGE: Years 66 Months 11 Days 13 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation..... None
 11. Industry or business..... None
 12. Name..... Thomas Philbin
 13. Birthplace..... Ireland
 14. Maiden name..... Mary McGowan
 15. Birthplace..... Baltimore

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland
 17. Burial Date thereof June 20, 1946
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory..... Cathedral
 Location..... Baltimore
 18. Funeral director..... H. W. Meunier
 Address..... 805 N. Calvert St.
 19. 6/19 46 Harry W. Miller
 (City or town) (year) (Registrar) (Signature) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 17..... 19 46..... at 5:25 pm
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 2..... 19 31..... to June 17..... 19 46.....
 and that I last saw him alive on June 17..... 19 46.....

Immediate cause of death.....
Coronary occlusion
 Due to..... Secondary anaemia, profound
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

DURATION

4 hours

Major findings of operations.....
 Date of op.....
 Autopsy results..... none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... Isadore Tuerk, M.D.
 Address..... Catonsville-28, Md. Date signed..... 7-18-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 22 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

05780

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Jones Creek Street Car Bridge
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 809 I St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Alvin Filcange
Flory Phillips

3. (b) Social Security Number

4. Sex

M

5. Color or race

Cal

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1931

8. AGE:

Years 15

Months

Days 3

If less than one day

hrs. min.

8. Birthplace

Sparrows Pt.
(Town, county, and state)

10. Usual occupation

School Boy

11. Industry or business

12. Name Rosale Phillips

13. Birthplace

Va.

14. Maiden name

Emma Sue Finney

15. Birthplace

MD.

16. Informant

Emma Sue Spruiell

Address

809 I St. Sparrows Pt.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

6-30-46
(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

A.C. Co.

18. Funeral director

Sam. W. Chase & Son

Address

638 N. Liberty St.

19. (Date rec'd by registrar)

6/28 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1946 to June 27 1946

and that I last saw him alive on June 27 1946

Immediate cause of death Drowning

(Accidental)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/27/46

Where did injury occur? Sparrows Pt. Balto. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Drowning Injured at work? No

23. SIGNATURE Dr. McCarroll M.D.

Dr. McCarroll M.D. Address Dr. McCarroll M.D.

Date signed 6/27/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05761

Reg. Dist. No.

42

1. PLACE OF DEATH:

County Baltimore
 City or town English Consulate
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town English Consulate
(If outside city or town limits, write RURAL and give nearest town)Street No. 27412 Way Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary L. Folk

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles

7. Birth date of deceased (mo., day, yr.)

Feb 17 1899

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4941

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

George T. Folk

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Marie Sommer

15. Birthplace

Baltimore, Md.

16. Informant

George T. Folk

Address

27412 Way Ave, English Consulate

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Greenwood

Location

Way Ave, English Consulate

18. Funeral director

Funeral Home

Address

1217 N. Bond St

19.

(Date rec'd by registrar)

19

46R. W. Redent

Registrar

23. SIGNATURE

Dr. C. Blake

M. D. or other

Address

Med. Arts Bldg.Date signed 6-22-46

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1946 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5 1946 to June 21 1946and that I last saw him alive on June 20 1946

Immediate cause of death

DURATION

Due to

Cardiac Dilatation48 hrs

Due to

Carcinoma of Lung

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Sept. 43: Removal ofbreast.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. C. Blake

M. D. or other

Address

Med. Arts Bldg.Date signed 6-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(11-a)

05762

44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1906 Queensway, Dundalk
(If rural, give LOCATION)2. (a) If veteran, name war WW#1

3. (a) FULL NAME

HERMAN T. POOLE

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Clausia Poole6. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) October 11, 1888

8. AGE: Years 57 Months 8 Days 18 If less than one day 1 hrs. 25 min.

9. Birthplace Colliers, W. Va.
(Town, county, and state)

10. Usual occupation

11. Industry or business Bethlehem Steel Co.12. Name Wilson Poole13. Birthplace unknown

14. Maiden name

15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof July 3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Balto National CemLocation Rural18. Funeral director Ulrich Funeral HomeAddress 2008 Orleans St21 46 Registrar

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1946 19... at 1:25 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19... 46 to 19...

and that I last saw him alive on 19...

Immediate cause of death UremiaDue to Nephritis, Chronic

Due to

Other conditions Disease of the Heart - hyper-tension, arterial; myocardial insufficiency
(Include pregnancy within 3 months of death)Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert M. Cullison23. SIGNATURE ROBERT M. CULLISON, M.D., CLIN. DIR.

M. D. or other

Address Fort Howard, Md. Date signed 6-29-46

DURATION

4 wksplus4 wks.plus4 mos.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05763

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Ba ltoCity or town Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

Red Lion Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Ba ltoCity or town Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)Street No. Red Lion Rd
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Charles W. Proctor

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Grace P Proctor

7. Birth date of

deceased (mo., day, yr.)

Sept. 19th 1869

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76822

hrs.

min.

9. Birthplace

Harford Co Md

(Town, county, and state)

10. Usual occupation

Telegraph Operator

11. Industry or business

B & O. R.R.

FATHER

12. Name

Wm Proctor

13. Birthplace

MOTHER

14. Maiden name

Mary

15. Birthplace

16. Informant

Mrs Harry Francis

Address

Red Lion Rd Whitemarsh

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

June 13th 1946
(month) (day) (year)

Cemetery or crematory

Camp Chapel Meth Cem

Location

Ba lto Co Md

18. Funeral director

Lassiter Funeral Home

Address

749 Belair Rd

19.

6/12/46
(Date rec'd by registrar)H M Emmett

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1946 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 20 1945 to June 6 1946and that I last saw him alive on June 6 1946

Immediate cause of death

Coronary Occlusion

DURATION

5 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. KolodnyAddress Ridge Rd. Balt. Co Md Date signed June 10 1946

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

STATE OF NEW YORK

DATE OF DEATH

NAME OF DECEASED

CITY OF NEW YORK

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RECEIVED
JUN 13 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AGE: Doctor's statement
 filmed 7-2-46 G104 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

05764

P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Balto.

City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
 46 Glenwood Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md..... County..... Balto.

City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 46 Glenwood Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

NELLIE RAY

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife..... --

7. Birth date of
 deceased (mo., day, yr.)

Apr. 24, 1873/ 1874

8. AGE:

73 Years

72 Months

27 Days

If less than one day

hrs. min.

9. Birthplace.....

Balto., Md.

(Town, county, and state)

10. Usual occupation..... --

11. Industry or business

FATHER

12. Name.....

William Ray

13. Birthplace

Ireland

MOTHER

14. Maiden name.....

Ellen Ryan

15. Birthplace

Balto., Md.

16. Informant.....

Mrs. Mary Schaeffer sister

Address

46 Glenwood Ave., Catonsville

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

6/24/46

(month) (day) (year)

Cemetery or crematory.....

Govans Presbyterian Cem.

Location.....

Govans, Md.

18. Funeral director.....

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 21, 1946, at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20, 1946, to June 20, 1946

and that I last saw h. RR. alive on 20 June 1946

Immediate cause of death.....

Cerebral hemorrhage

DURATION

2 hrs

Due to.....

Hypertension

Usual

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Stephen Lee Magness M.D.

M. D. or other

Address..... 752 Frederick Ave Date signed..... 22 June 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B14)

CERTIFICATE OF DEATH

Reg. Dist. No.

05765-11

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Dundalk</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>26 years</u> Hospital, institution, or street address where death occurred: <u>4 Newship Road</u> How long in hospital or institution?.....					2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Dundalk</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>4 Newship Road</u> (If rural, give LOCATION) 2(a) If veteran, name war.....				
3. (a) FULL NAME <u>Augustus C. Reinhardt</u>					3. (b) Social Security Number				
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>					
6. (b) Name of husband or wife <u>Ella Wetzel</u>					6. (c) If alive, give age years				
7. Birth date of deceased (mo., day, yr.) <u>June 9, 1871</u>									
8. AGE: Years <u>75</u>		Months <u>0</u>		Days <u>4</u>		If less than one day hrs. min.			
9. Birthplace <u>Baltimore, Maryland</u> (Town, county, and state)									
10. Usual occupation <u>Retired</u>									
11. Industry or business -----									
FATHER	12. Name <u>Charles Reinhardt</u>								
	13. Birthplace <u>Baltimore, Maryland</u>								
MOTHER	14. Maiden name <u>Virginia Coulter</u>								
	15. Birthplace <u>Pennsylvania</u>								
16. Informant <u>Mrs. Ella W. Reinhardt</u> Address <u>4 Newship Road</u>									
17. Burial (Burial, cremation, or removal. Which?) Cemetery or crematory..... <u>Baltimore</u> <u>Baltimore, Md.</u> Location.....					Date thereat..... <u>6/17/46</u> (month) (day) (year)				
18. Funeral director <u>W. W. Means and Son</u> Address <u>805 N. Calvert Street</u>									
19. 6-17 (Date rec'd by registrar)					19. 46 <u>Am. Red Cross</u> Registrar				

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>June 13, 1946</u> at <u>2 PM</u>	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from19..... to.....19..... and that I last saw him alive on <u>June 13, 1946</u> Immediate cause of death..... <u>Coronary thrombosis</u> <u>Chronic nephritis</u> <u>Secondary anemia</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.	DURATION <u>1 day</u> <u>2 years</u> <u>2 years</u>
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?	
23. SIGNATURE <u>David H. Andrew M.D.</u> Address..... Date signed.....	M. D. or other <u>June 14, 1946</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-0

05766

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County Balto.
 City or town Halethorpe
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
5557 Oregon Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Halethorpe
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5557 Oregon Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

HARRY A. RETTBERG

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Margaret Clayland Rettberg
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Oct. 31, 1871
 8. AGE: Years 74 Months 7 Days 29 If less than one day hrs. min.

9. Birthplace Hagerstown, Md.
 (Town, county, and state)
 10. Usual occupation Shoe Salesman (Retired)
 11. Industry or business

FATHER 12. Name Louis Rettberg
 13. Birthplace Hagerstown
 MOTHER 14. Maiden name Mary Potee
 15. Birthplace Md.

16. Informant Mrs. Howard H. Hine
 Address 5557 Oregon Ave.

17. Burial Date thereof 6/22/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park Cem.
 Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
 Address Balto., Md.

19. (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20/46 19..... at 11:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to June 20 - 1946
 and that I last saw him alive on June 19 - 1946

Immediate cause of death Carcinoma soft palate
 DURATION 7

Due to
 Due to

Other condition Meloidosis carcinoma glands
and metastasis
 (Include pregnancy within 3 months of death)

Major findings of operations Microscopic soft palate
no pharynx right Date of op. 7
 Autopsy results 5 grams cells carcinoma GPO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Frederic V. Bester M. D. or other
 Address 723 Medicine Arts Bldg - Date signed 6-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05767

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 168 DaysHospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard. Md.How long in hospital or institution? 168 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1520 Jefferson St.,
(If rural, give LOCATION)2.(d) If veteran, name War SAW

3. (a) FULL NAME

MELVIN ROBERTS

3. (b) Social Security Number

4. Sex

male

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife Single

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 12-25-18758. AGE: Years Months Days If less than one day
70 5 15 _____ hrs. _____ min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Daniel Roberts13. Birthplace Virginia14. Maiden name Sarah Woods15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Md.17. Burial Date thereof _____ (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.18. Funeral director Charles R. LawAddress 802 Madison Ave Balto., Md.19. June 14 19 46 Robert M. Cullison Registrar

Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 19 46, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 25, 19 45, to June 11, 19 46and that I last saw him alive on June 11, 19 46Immediate cause of death Pulmonary Edema

DURATION

6 Hrs.Due to Hypertensive & CoronaryArteriosclerotic heart disease1-1/2yrs. plus.

Due to _____

Other conditions Psychosis with cerebralArteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. CullisonR. M. Cullison, M.D. Clin. Dir.Address Ft. Howard, Md. Date signed 6-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
 Franklin & Ingleside

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
 County.....

City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

THOMAS PLATT ROSE

3. (b) Social Security Number

4. Sex.....
 Male

5. Color or race.....
 White

6.(a) Single, married, widowed, or divorced.....
 Married

6.(b) Name of husband or wife.....
 Mary Brooke Rose

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....
 July 7, 1868

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.....
 (Burial, cremation, or removal. Which?) Date thereof.....
 (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.....
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18, 1946 at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 June 18, 1946 to June 18, 1946
 and that I last saw him/her on June 18, 1946

Immediate cause of death.....

Other conditions.....

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05769

44

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. 1907 EASTERN AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

IRMA Rosenberg

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife WilliamRosenberger 6. (c) If alive, give age 38 years7. Birth date of deceased (mo., day, yr.) Nov. 8 - 19098. AGE: Years 36 Months 6 Days 28 If less than one day
hrs. min.9. Birthplace Albany, N. Y.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Julius Shoreman13. Birthplace N. Y.14. Maiden name Unknown

15. Birthplace

16. Informant Mr. J. RosenbergerAddress 1907 Eastern Ave. East17. Burial Date thereof June 8 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Eastern Blvd.18. Funeral director Wm. G. ConnollyAddress 418 Eastern Ave. East19. June 8 19. 46 Wm. G. Connolly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19. 46 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19., fo. 19.

and that I last saw him alive on 19.

Immediate cause of death BARBITURIC Acid.POISONING -Due to TOXIC CAPS (16)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Undetermined Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. G. ConnollySup. Med. Exam. (Phys.)Address Sumner St. Date signed 6/8/46

DURATION

6 hrs.

05720

MAILED 10 1966

RECEIVED

ARTS & CRAFTS

PASADENA

RECEIVED
JUN 11 1966
ETC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

05770



Reg. Dist. No. 33

1. PLACE OF DEATH: Baltimore
 County Baltimore
 City or town DRUID RIDGE (OAKLAWN CEMETERY)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Essex
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Jacob A. Sauble

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ruth E. Sauble

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1877 6. (c) If alive, give age _____ years

8. AGE: Years 68 Months 9 Days 5 It less than one day _____ hrs. _____ min.

9. Birthplace Frederick Co.
 (Town, county, and state)

10. Usual occupation Employed at Oak Lawn Cemetery

11. Industry or business _____

12. Name Wm. Sauble

13. Birthplace Md.

14. Maiden name Mary Garger

15. Birthplace Md.

16. Informant Mrs. Ruth E. Sauble

Address Glyndon, Md.

17. Burial Date thereof June 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Balto. Co.

18. Funeral director J.F. Eline & Sons

Address Reisterstown, Md.

19. 6-7 19 46 Dora B. Eline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 19 46 at 4-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Coronary Occlusion DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. Bravis M.D.

Address Dept. of Health - Baltimore

Date signed 6/6/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

MEMORANDUM FOR THE SECRETARY

SUBJECT: RAG CONTENT

1. The following information is being furnished to you for your information.

2. The information is being furnished to you for your information.

3. The information is being furnished to you for your information.

4. The information is being furnished to you for your information.

RECEIVED

JUN 11 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05771

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH
County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State MD County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bogwood Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Gilbert Hamilton Sauter

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Frances Estelle Sauter
7. Birth date of deceased (mo., day, yr.) Sept. 18 1867 6. (c) If alive, give age 79 years
8. AGE: Years 77 Months 8 Days 27 If less than one day hrs. min.
9. Birthplace Baltimore Co. MD.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
12. Name Gilbert H. Sauter
13. Birthplace Bermany
14. Maiden name Margaret Ann Thomas
15. Birthplace Maryland
16. Informant Ms. Frances E. Sauter
Address Bogwood Rd. Woodlawn. MD
17. Burial Date thereof June 17 1946
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematorium Lorraine Park
Location Baltimore Co. MD
18. Funeral director Dr. J. L. Lumsden
Address 4510 Liberty Heights Ave
19. 6/15/46 19 46 Mr. E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 46 at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 19 46 to June 15 19 46
and that I last saw him alive on June 14 19 46
Immediate cause of death Cerebral hemorrhage
Due to Cardiovascular Disease
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Mr. E. Martin M. D. or other
Randallston Date signed 6/15/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 20 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05772

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Days
 Hospital, institution, or street address where death occurred:
Vet. Adm. Hosp. Fort Howard, Maryland
 How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. #9, Box 395
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-II ★

3. (a) FULL NAME

JAMES S. SAVAGE

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 7, 1925
 8. AGE: Years 20 Months 11 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name Richard Francis
 13. Birthplace North Carolina
 14. Maiden name Beulah Savage
 15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Ft. Howard, Md.

17. Burial Date thereof 6-19-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Md.

16. Funeral director Charles R. Law
 Address 802 Madison Ave, Balto., Md.

19. 6-18-46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1946 at 7:20 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11th 1946 to June 15, 1946
 and that I last saw him alive on June 15, 1946
 Immediate cause of death Chronic Glomerular nephritis DURATION 1-1/2 Yrs.

Due to _____
 Due to _____
 Other conditions Hypertension
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results Substantiated above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Robert M. Collison
R.M. COLLISON, M.D. CLIN. M.D. or other
 Address Ft. Howard, Md. Date signed 6-17-46

05772

UNITED STATES OF AMERICA
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1915

PLANT INDUSTRY

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
DEPARTMENT OF AGRICULTURE
UNITED STATES OF AMERICA
WASHINGTON, D. C.
1915

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
DEPARTMENT OF AGRICULTURE
UNITED STATES OF AMERICA
WASHINGTON, D. C.
1915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05773

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. Bingues & Hampler Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Angela Schepers

3. (b) Social Security Number

4. Sex

F.

5. Color or race

A.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

BernardSchepers6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.)

Oct. 1 - 1876

8. AGE:

Years 70Months 8Days 8

If less than one day

hrs.

min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Bernard Renter

13. Birthplace

Germany

14. Maiden name

Unknown

15. Birthplace

LI

16. Informant

Bernard Schepers

Address

Middle River

17.

Burial

Date thereof

June 12 - 46
(month) (day) (year)

Cemetery or crematory

Cobenez

Location

Cobenez Road M.R.

18. Funeral director

John S. Connelly

Address

418 Eastern Ave. Pikes

19.

June 10

19

46John S. Connelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 46 at 7:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 919 46to June 919 46

and that I last saw h. alive on 19

Immediate cause of death

HEART FAILURE

DURATION

Due to

ARTERIOSCLEROTIC CARDIO
VASCULAR DISEASE

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stephen C. Mackowiak M.D.deputy medical examiner
M. D. or other

Address

6714 Holabird Ave

Date signed

June 9, 1946

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 921

05774

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH: <u>Baltimore</u> County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 wks.</u> Hospital, institution, or street address where death occurred: <u>Epik Nursing Home</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>md</u> County..... <u>Baltimore</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>1304 Rice Ave</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Mary Ellen Schuh</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>			
6. (b) Name of husband or wife <u>John X</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Nov. 25, 1867</u>				8. AGE: Years <u>78</u> Months <u>7</u> Days..... If less than one day..... hrs. min.			
9. Birthplace <u>Glasbury, England</u> (Town, county, and state)				10. Usual occupation <u>Housewife</u>			
11. Industry or business				12. Name <u>Benjamin Barber</u>			
13. Birthplace <u>England</u>				14. Maiden name <u>Ellen Minards</u>			
15. Birthplace <u>England</u>				16. Informant <u>Mrs. Ida Cooke</u> Address <u>1304 Rice Ave</u>			
17. REMOVAL (Burial, cremation, or removal. Which?) <u>Brookside</u> Cemetery or crematory..... Location..... <u>Englewood Mt.</u> 18. Funeral director <u>William J. Dickner</u> Address <u>North La Aves.</u> 19. <u>6-26-46</u> <u>Inspector</u> (Date rec'd by registrar) Registrar				MEDICAL CERTIFICATION 20. DATE OF DEATH <u>6/25/46</u> <u>46</u> <u>4 PM</u> <u>30</u> M 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>18 April</u> <u>19 46</u> <u>to 25 June</u> <u>19 46</u> and that I last saw her alive on <u>25 June</u> <u>19 46</u> Immediate cause of death <u>Broncho pneumonia</u> Due to <u>Pulmonary STASIS</u> Due to <u>Arteriosclerotic cardiac vascular disease</u> Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations Date of op..... Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of Injury..... Injured at work?..... 23. SIGNATURE <u>Stephen Lee Magness MD</u> M. D. or other Address <u>752 Frederick Ave</u> Date signed <u>26 June '46</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05775

Reg. Dist. No. 4/

1. PLACE OF DEATH: County... <u>Baltimore</u> City or town... <u>Dundalk</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Md.</u> County... <u>Baltimore</u> City or town... <u>Dundalk</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1902 Monroe Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Katie Sebal</u>				3. (b) Social Security Number			
4. Sex <u>female</u>		5. Color or race <u>white</u>		6.(a) Single, married, widowed, or divorced <u>widow</u>		MEDICAL CERTIFICATION	
6.(b) Name of husband or wife <u>Mark Sebal</u>				20. DATE OF DEATH <u>June 18</u> 19 <u>46</u> at <u>7:19</u> M			
7. Birth date of deceased (mo., day, yr.) <u>Nov. 1, 1878</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>6/14</u> 19 <u>46</u> to <u>6/18</u> 19 <u>46</u> and that I last saw him/her alive on <u>6/17</u> 19 <u>46</u>			
8. AGE: Years <u>67</u> Months <u>7</u> Days <u>17</u> If less than one dayhrs.min.		5.(c) If alive, give age years		Immediate cause of death <u>Myocarditis</u>			
9. Birthplace <u>Yugoslavia</u> (Town, county, and state)		10. Usual occupation <u>none</u>		Due to <u>hypertension</u>			
11. Industry or business		12. Name <u>Ivkovic</u>		Due to <u>arteriosclerosis</u>			
13. Birthplace		14. Maiden name <u>Magdeline</u>		Other conditions			
15. Birthplace		16. Informant <u>Mrs Favin Lucich</u> Address <u>1902 Monroe Road, Dundalk</u>		(Include pregnancy within 3 months of death)			
17. Burial (Burial, cremation, or removal. Which?) Cemetery or crematory <u>ST. Stanislaus</u> Location <u>Dundalk Ave.</u>		18. Funeral director <u>Roland L. Fisher</u> Address <u>2112 Dundalk Ave.</u>		Major findings of operations Date of op.			
19. 6-20-46 (Date rec'd by registrar)		20. Registrar <u>[Signature]</u>		Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
21. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of		22. Where did injury occur? (City or town) (County) (State)		Injured at home, farm, industry, public place (where?)			
23. Means of injury		Injured at work?		24. SIGNATURE <u>[Signature]</u> M. D. or other			
25. Address <u>[Signature]</u>		26. Date signed <u>6/19/46</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05776

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BALTIMORE
 City or town 5501 EDMONDSON AVE., CATONSVILLE, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 55 YEARS IN CATONSVILLE
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County BALTIMORE
 City or town CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 715 FREDERICK AVE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war NONE

3. (a) FULL NAME

EFFIE ELLEN SEICKE

3. (b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOW

6. (b) Name of husband or wife

FREDERICK A. SEICKE

7. Birth date of

deceased (mo., day, yr.)

MARCH 5, 1867.

8. AGE:

Years

Months

Days

If less than one day

79

3

24

hrs. min.

9. Birthplace

CARROLL CO. MARYLAND.

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

FATHER

12. Name

SYLVANIUS LIPPY

MOTHER

13. Birthplace

CARROLL CO. MD.

14. Maiden name

SUSAN KROH

15. Birthplace

CARROLL CO. MD.

16. Informant

MR. CLARENCE F. SEICKE

Address 308 FREDERICK AVE. CATONSVILLE, MD.

17.

BURIAL

Date thereof 6/2 8/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

SALEM LUTHERAN CEMETERY

Location

CATONSVILLE, MD.

18. Funeral director

Easton Sons

Address

608 Frederick Ave. Catonsville, Md.

19.

(Data rec'd by registrar)

6-28 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 25 th. 19 46 at 1:02 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Mar 15 19 46 to June 25 19 46
 and that I last saw him alive on June 25 19 46

Immediate cause of death

Carcinoma of Rectum
with metastases

DURATION

6 mos

Due to

to liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECU
JUL 1 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05777

Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore
 City or town Deer Park
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louis Jean Sellman

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Beulah D. Dosh

7. Birth date of

deceased (mo., day, yr.)

June 29, 18896. (c) If alive, give age 1 years

8. AGE:

Years

Months

Days

If less than one day

57112

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER

FATHER

12. Name

Louis M. Sellman

13. Birthplace

Md.

14. Maternal name

Birdie Jean

15. Birthplace

Md.

16. Informant

Mrs. Beulah Sellman

Address

Randalltown, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

June 4, 1946
(month) (day) (year)

Cemetery or crematory

Mt. Paran. Cem.

Location

Harrisonville, Balt. Co., Md.

18. Funeral director

C. Harry Green

Address

Highsville, Md.

19.

(Date rec'd by registrar)

19

46Tom E. Martin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Harrisonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Liberty Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 1

19

46 at 7:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1946 to June 1 1946and that I last saw him dead on June 1 1946

Immediate cause of death

Coronary Occlusion

DURATION

10 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. D. Caples, M. D. Exam.

M. D. or other

Address

Reisterstown, Md.Date signed June 1, 46

RECEIVED
JUL 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-1)

05778

CERTIFICATE OF DEATH

Reg. Dist. No. 4843

1. PLACE OF DEATH:

County BaltimoreCity or town Paspeburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

12 Madaline Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Ba 1 to CoCity or town Paspeburg Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 Madaline Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Burton W. Sheeler

3. (b) Social Security Number

212-01-3372

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Catherine Sheeler

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/8/82

8. AGE: Years Months Days If less than one day

63 11 1 hrs. min.9. Birthplace Balto. Md
(Town, county, and state)10. Usual occupation Salesman11. Industry or business Shoe Co.12. Name Geo. Sheeler13. Birthplace Balto. Md14. Maiden name Eleanora Williams15. Birthplace Anne Arundel Co. Md.16. Informant Mrs. B. W. SheelerAddress 12 Madaline Ave17. Cremation Date thereof 6 12 46
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory London ParkLocation Balto. Md18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Rd19. June 10 19 46 Mrs. J. L. Reifmiller
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 19 46 at 6¹⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-7 19 46 to 6/9 19 46and that I last saw him alive on 6/8 19 46

Immediate cause of death

Myocardial Degeneration

DURATION

2 yearsDue to Coronary arteriosclerotic heart disease5 years

Due to

Other conditions Cerebral embolism; (6 mos)Pneumonia; parotitis (bilateral)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE J. L. Reifmiller M. D. or otherAddress 6331 Belair Road Date signed 6/10/1946

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
JUN 13 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

CERTIFICATE OF DEATH

05779

Reg. Dist. No.

35

1. PLACE OF DEATH: County <u>Balto.</u> City or town <u>SPARKS, Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>9 years</u> Hospital, institution, or street address where death occurred: <u>3 PARKS, Md.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Rural near Sparks</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>North of Sparks</u> (If rural, give LOCATION) 2(a) If veteran, name war			
3. (a) FULL NAME <u>Zenna Irene Sheets</u>				3. (b) Social Security Number 			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married.</u>			
6. (b) Name of husband or wife <u>Webb, Sheets</u>				6. (c) If alive, give age <u>37</u> years			
7. Birth date of deceased (mo., day, yr.) <u>December 23, 1909</u>				8. AGE: Years <u>36</u> Months <u>6</u> Days <u>5</u> If less than one day _____ hrs. _____ min.			
9. Birthplace <u>Chilhowie, VA.</u> (Town, county, and state)				10. Usual occupation <u>Housewife.</u>			
11. Industry or business <u>Own home</u>				12. Name <u>John A. Blevins</u>			
13. Birthplace <u>Chilhowie, VA.</u>				14. Maiden name <u>Mary Ellen Blevins</u>			
15. Birthplace <u>Tenn.</u>				16. Informant <u>Mrs. Lenard Davis</u> Address <u>Freeland, Md. Rd.</u>			
17. Removal (Burial, cremation, or removal. Which?) <u>Removal</u> Date thereof <u>June 28, 1946</u> (month) (day) (year)				18. Funeral director <u>Joseph J. Fust</u> Address <u>New Freedom, Pa.</u>			
19. Date rec'd by registrar <u>June 29, 1946</u>				20. MEDICAL CERTIFICATION 20. DATE OF DEATH <u>June 28, 1946</u> at <u>2:30</u> P.M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June 21, 1946</u> to <u>June 28, 1946</u> and that I last saw him alive on <u>June 28, 1946</u> Immediate cause of death <u>Chronic myocarditis</u> DURATION _____ Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____				23. SIGNATURE <u>G. In. France</u> Address <u>Parliamentary Ind</u> Date signed <u>6/28/46</u> Registrar <u>Joseph J. Fust</u>			

RECEIVED

JUL 5 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05780

Reg. Dist. No. 38

1. PLACE OF DEATH

County Baltimore
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 215 Chesapeake Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie Smith

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow8. (b) Name of husband or wife George W. Smith

7. Birth date of deceased (mo., day, yr.)

July 21, 1864

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

81 10 15 hrs. min.9. Birthplace Westminster, Md.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home12. Name Lucretius Wampler13. Birthplace Md.14. Maiden name Elizabeth Zouck15. Birthplace Md.15. Informant Mrs. Gertrude MoretonAddress 215 Chesapeake Ave, Towson, Md.17. Burial Date thereof June 8, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St Pauls & B.Location Lineboro, Md. R.D.18. Funeral director Wickham & SonsAddress New Ferry, Md.19. June 6, 1946 Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1946 at 9:27

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to June 4, 1946and that I last saw her alive on June 4, 1946

Immediate cause of death

Cardiac insufficiency

DURATION

Due to Paralysis left sideDue to Smile degeneration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

25. SIGNATURE Roscoe H. Ross

M. D. or other

Address 2438 Maryland Ave Date signed June 6, 1946Baltimore, Md.

MARGIN RESERVED FOR BINDING

VS-A16 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 20 1946
BUREAU T. R.

Cambridge
ARTESIAN LEADER
RAC-CONTE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05781

31

1. PLACE OF DEATH

County Baltimore
 City or town Woodlawn
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19. (Date filed by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 15, 1946

at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15, 1946

and that I last saw him alive on June 14, 1946

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53⁰

1. PLACE OF DEATH:

(a) Baltimore City, Maryland *Baltimore*(b) Street address *Garrison*(c) Hospital or institution *Garrison*

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Balto Co.*(c) City or town *Garrison*
(If outside city or town limits, write RURAL and give town)(d) Street No. *Reisterstown Rd*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME *Alvin A. Spurrer*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *M*5. Color or race *W.*6 (a) Single, married, widowed, or divorced *Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *3/10/1904*8. AGE: Years *46* Months *3* Days *13* hr. min.9. Birthplace *Balto Co. Md.*
(Town, county, and state)10. Usual Occupation *clerk*11. Industry or business *BYORR*12. Name *Anthony Spurrer*13. Birthplace *Md.*14. Maiden Name *Kate Kramer*15. Birthplace *Balto Md.*16 (a) Informant *Kate Spurrer*(b) Address *Garrison Balto Co. Md.*17 (a) *Burial* (b) Date thereof *6/26/46*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Lawdon Park*
Location *Fredrick Rd.*18 (a) Funeral director *Edward Louder*(b) Address *2359 Wagh Blvd.*19 (a) *6/25/46* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *6/23/46*, at *Garrison* M21. I certify that death occurred on the date above stated; that I attended deceased from *1-1-1938* to *6/23/46* and that I last saw him alive on *6/1/46*

Immediate cause of death

*Myocardial Chronic Decompensation*Due to *Sclerosis of spinal cord*Due to *nephritis chronic*

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *John G. Saffell*Address *Reisterstown Rd* Date signed *6/24/46*

PHYSICIAN

Underline the cause to which death should be charged statistically:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05783

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balt. Co.City or town Edgemore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balt.City or town Edgemore
(If outside city or town limits, write RURAL and give nearest town)Street No. Brannan Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Olive Elmina Thumma

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mitchell Thumma

7. Birth date of deceased (mo., day, yr.)

July 30, 18848.(c) If alive, give age D years

8. AGE:

Years

Months

Days

If less than one day

61

hrs. min.

9. Birthplace

Pennsylvania
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none

FATHER

12. Name

Harry Rodkey

13. Birthplace

unknown

14. Maiden name

Chalmer's Island

MOTHER

15. Birthplace

unknown

16. Informant

Mr. Benjamin F. Thumma

Address

2403 Sparrows Point Rd

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

ST. PAUL CEM. - CARDIFF AVE

Location

O'Donnell St.

18. Funeral director

John F. Henry Inc.

Address

714 Bright St.

19.

(Date rec'd by registrar)

6/7A W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5/46 19 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1946 to 6.5/46 19 6.5/46and that I last saw him alive on 6.5.46 19 6.5.46

Immediate cause of death

Coronary Occlusion

DURATION

3 days

Due to

Arteriosclerotic cardiovascular disease?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. B. Jones, M.D.

M. D. or other

Address 520 D St. Date signed 8/17/46

Rev. Bartone:-

Use

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. NAVY 7001 MORNINGTON ROAD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05784

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
 City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)Street No. 2616 Liberty Parkway
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

JEREMIAH M TILLER

3.(b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

B.(b) Name of husband or wife

Emma

August 10, 1852

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

August 10, 1852

8. AGE:

Years

Months

Days

If less than one day

93

9

23

hrs.

min.

9. Birthplace

Richmond, Va.

(Town, county, and state)

10. Usual occupation

Grocery Proprietor

11. Industry or business

Own

FATHER

12. Name

Robert Tiller

13. Birthplace

Richmond, Va

MOTHER

14. Maiden name

(?) Stanley

15. Birthplace

Richmond, Va.

18. Informant

Norman Atkins

Address

2616 Liberty Parkway

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof, June 5, 1946
 (month) (day) (year)

Cemetery or crematory

Oaklawn

Location

Baltimore Co. Maryland

18. Funeral director

William Cook, Inc.,

Address

1217 St. Paul Street

19.

(Date rec'd by registrar)

19.

x6

D.W. Hedrick

B.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1946 at C.P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 25, 1946, to June 3, 1946

and that I last saw him alive on June 3, 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Hyper tension
 Cardiovascular Disease

Due to

Generalized
 arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eugene F. Navy M.D.

M. D. or other

Address 7001 Mornington Rd Date signed 6-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 44

CERTIFICATE OF DEATH

05785

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Rosedale
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. _____
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Mary Theresa Todd

3 (b) If veteran, name war

3 (c) Social Security

No. _____

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Geo. D. Todd

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

2/17/1878

8. AGE:

Years 68

Months _____

Days _____

If less than one day

hr. _____

min. _____

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

11. Industry or business

At home

MOTHER FATHER

12. Name

John Prompter

13. Birthplace

Berks, Pa.

14. Maiden Name

Theresa Conte

15. Birthplace

Berks, Pa.

16 (a) Informant

Geo. D. Todd

(b) Address

6104 Hamilton Ave

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

June 10

(month) (day) (year)

(c) Cemetery or crematory

Baltimore City

Location

18 (a) Funeral director

Union Funeral Home

(b) Address

2008 Orleans St

19 (a)

6/8/46

(Date rec'd by Registrar)

(b)

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. Date of death June 7 1946, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1946, to June 7 1946 and that I last saw him alive on June 7 1946.

Immediate cause of death

Coronary Thrombosis

Duration

12 hrs

Due to

Arterio-sclerotic cardiac

Due to

vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
 (Specify type of place)
 (e) Means of injury _____

23. Signature

Geo. M. Baumgardner

M. D. or other

Address Balto 6 md

Date signed 6-7-46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Film No. 106 - 7/24/46 is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**
 of deceased is shown on 2411 N. Charles St., Baltimore (46)
 Film No. 106 - 7/24/46 **CERTIFICATE OF DEATH**

05786

Reg. Dist. No. 44

1. PLACE OF DEATH:County Balto.City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2011 Dundalk Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)Street No. 2011 Dundalk Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAMEWilliam M. Tracey**3. (b) Social Security Number**

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 7 - 1876

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69-70

hrs.

min.

9. Birthplace

Carroll Co.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

James F. Tracey

13. Birthplace

Ohio

MOTHER

14. Maiden name

Matilda A. Campbell

15. Birthplace

Carroll Co.

16. Informant

Sister

Address

2011 Dundalk Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

6/20/46
 (month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

Germond Hill Rd.

18. Funeral director

John J. Connelly

Address

418 Eastern Ave. Essex 21

19.

(Date rec'd by registrar)

6/20/46
Frank Armone

Registrar

MEDICAL CERTIFICATION20. DATE OF DEATH June 18 19 46 at MD

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1946 to June 18 1946and that I last saw him alive on June 18 1946

Immediate cause of death

Carcinoma of stomach

Due to

Due to

Metastasis general

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Armone M.D.

M. D. or other

Address Dundalk Md Date signed 6/20/46

RECEIVED

JUL 17 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

CERTIFICATE OF DEATH

05787

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md. County...
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 536 N. Castle St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

James Edward Walter

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife...
 7. Birth date of deceased (mo., day, yr.) May 15, 1907 6. (c) If alive, give age... years
 8. AGE: Years 39 Months 1 Days 6 If less than one day... hrs. ... min.

9. Birthplace Baltimore, Md
 (Town, county, and state)
 10. Usual occupation... None
 11. Industry or business None

12. Name John Walter
 13. Birthplace Baltimore, Md.
 14. Maiden name Mamie Glas
 15. Birthplace Baltimore, Md

16. Informant Hospital Records
 Address Catonsville 28, Md.

17. Burial Date thereof June 25th
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory London Park Cem
 Location City

18. Funeral director Walter Funeral Home
 Address 2008 Orleans St

19. 6-24-46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 46 at 4:50 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 14 19 46 to June 21 19 46
 and that I last saw him alive on June 21 19 46
 Immediate cause of death Acute Myocarditis
 Due to Fever Undetermined origin
 Due to Little's Disease
 Other conditions None

DURATION

Minutes
2 days
Life-long

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. ...
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Isadore Frank, M.D. M. D. or other
Spring Grove State Hosp.
 Address Catonsville, Md. Date signed June 21, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05788

Reg. Dist. No. *SP*

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs 6 mo, 9 days
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? 2 yrs 6 mo 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Ashlton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 943 Church St.
 (If rural give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Conway L. Ward

3. (b) Social Security Number

705-05-0996

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Lora F. Ward
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Jan 22 1900
 8. AGE: Years 46 Months 4 Days 12 If less than one day
 hrs. min.

9. Birthplace Alabama
 (Town, county, and state)
 10. Usual occupation Pipe fitter
 11. Industry or business Contracting
 12. Name Karoline Ward
 13. Birthplace Tuscaloosa Alabama
 14. Maiden name Cordelia Clement
 15. Birthplace Tuscaloosa Alabama

16. Personal History- Hospital Records

Address Eudowood Sanatorium, Towson 4, Md.
 17. Burial Date thereof 6/5/46
 (Burial, cremation, or removal? What?) (month) (day) (year)
 Cemetery or crematory Meadow Ridge
 Location Dorsey, Md.
 18. Funeral director William Cook, Inc.
 Address 1217 St. Paul St.
 19. 6-4-46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1946 at 5:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1943 to June 3 1946
 and that I last saw him alive on June 2 1946
 Immediate cause of death Pulmonary T.B.
 DURATION 4 yrs
 Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE W. A. Bridges M. D. or other
 Address Towson 4, Maryland Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05789

4X

1. PLACE OF DEATH:

County Balto.
 City or town Sparks Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 mos.
 Hospital, institution, or street address where death occurred:
2516 Sycamore ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Sparks Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2516 Sycamore ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Henry Weston.

3. (b) Social Security Number

4. Sex male 5. Color or race Chl. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan 12/1946.

8. AGE: Years 5 Months 11 Days It less than one day
 hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Child

11. Industry or business

12. Name William H. Weston

13. Birthplace Virginia

14. Maiden name Sarah James

15. Birthplace N.C.

16. Informant Sarah Weston

Address 2516 Sycamore ave

17. Burial Date thereof June 25/1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Calvary

Location Brooklyn, Md

18. Funeral director Eloy O. Wilson

Address 1000 Brantly ave

19. 6/24/46 (Date rec'd by registrar)

Registrar X

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23/46, at 7A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19....., 19....., 19....., 19.....
 and that I last saw h..... alive on 19.....

Immediate cause of death Malnutrition
Sleo orbits
 Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

SIGNATURE J. McFarlane, M.D.
 Address Dep't of Medical Examiner
Baltimore, Md. Date signed 6/25/46

White Oak Park

Chickadee

1679

63

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

05790

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
 City or town Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos.
 Hospital, institution, or street address where death occurred:
Turner River Beach
146 Bird Dale ave.
 How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Balto.
 City or town Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 146 Birdale Ave. of Turner River
 (If rural, give LOCATION)
 2. (a) If veteran, name war:

3. (a) FULL NAME

Joan Elizabeth Wilhelm.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) Aug. 10/1932

8. AGE: Years 13 Months 10 Days 14 If less than one day hrs. min.

9. Birthplace Boston, Mass.
 (Town, county, and state)

10. Usual occupation Schoolgirl

11. Industry or business

12. Name John E. Wilhelm
 13. Birthplace Reno, Pa.

14. Maiden name Priscilla
 15. Birthplace Malden, Mass.

16. Informant ParentsAddress 146 Bird Dale Ave.

17. Burial Date thereof June 27-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart CemeteryLocation German Hill Road.18. Funeral director John S. ConnollyAddress 418 Eastern Ave. Wash.

19. June 26 19 46 John S. Connolly
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1946 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death..... DURATION

Drowning (Accidental)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/24/46Where did injury occur? Chase Balto. md.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public PlaceMeans of injury Drowning Injured at work? No.23. SIGNATURE Dr. M. J. ConnollyAddress Deputy Medical ExaminerDate signed 6/24/46

RECEIVED
JUL 5 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 925

CERTIFICATE OF DEATH

05791

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto Co
 City or town 5538 Link Ave Gbutes
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto
 City or town Gbutes
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5538 Link Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

Leo S Wilson

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White ✓

6. (b) Name of husband or wife Rose S Wilson7. Birth date of deceased (mo., day, yr.) August 18, 1892 6. (c) If alive, give age 53 years

8. AGE: Years Months Days If less than one day

57 2 19 hrs. min.

9. Birthplace Balto Md10. Usual occupation Bartender

11. Industry or business

12. Name Allen S Wilson13. Birthplace Balto Md14. Maiden name James Dorsey15. Birthplace Balto Md16. Informant Mrs. Rose WilsonAddress 5538 Link Ave17. (Burial, cremation, or removal. Which?) Burial Date thereof 6-14-46Cemetery or crematory Baltimore NationalLocation 5501 Frederick Ave18. Funeral director Frederick G. ColeAddress 1200 W. Lombard St.19. 6-13 46 Cremation

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11 19 46, at 87 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10 19 46 to 6/11 19 46and that I last saw him alive on 6/11/46 19 46Immediate cause of death Myocardial RegurgitationDURATION 3 mo

Due to

Due to

Other conditions Myocardial Regurgitation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sam Miller MDAddress 1200 W. Lombard St.Date signed 6/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05792

Reg. Dist. No. 32

1. PLACE OF DEATH:
 County Baltimore
 City or town Mount Wilson, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 7 mos., 22 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 0 yrs., 7 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Wicomico Co.
 City or town Parsonsborg, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Mrs. Vivian S. Wimbrow

3. (b) Social Security Number
Unknown

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Charles F. Wimbrow
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 22, 1920
 8. AGE: Years 26 Months 3 Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Stockholm, Maine
 (Town, county, and state)
 10. Usual occupation Bkpr. and Accounting
 11. Industry or business _____
 12. Name John C. Sjostedt
 13. Birthplace Sweden
 14. Maiden name Anna Christine
 15. Birthplace Sweden

16. Informant Mrs. Vivian S. Wimbrow
 Address Parsonsborg, Maryland
 17. Burial Removal Date thereof June 22, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location Stockholm, Maine
 18. Funeral director Halloway & Company
 Address Salisbury, Maryland
 19. June 21, 1946
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1946 at 3:15 A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1945 to June 21, 1946
 and that I last saw him alive on June 21, 1946
 Immediate cause of death Pulmonary Tuberculosis DURATION 15 Mos.
 Due to Tubercle Bacilli
 Due to _____
 Other conditions Tuberculous Meningitis 2 Wks.
 (Include pregnancy within 3 months of death)
 Major findings of operations No operation
 _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other _____
 Address Mt. Wilson, Md. Date signed 6/21/46

Rec'd 6-24-46 Dr. E. E. Nichols mvd

RECEIVED
JUN 25 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

CERTIFICATE OF DEATH

05793

Reg. Dist. No. X/

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? 87 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Balto. Co.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 219 Dumbarton Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war SAW

3. (a) FULL NAME

GEORGE E. WINDER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Cary Winder
6. (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) 10-24-79
8. AGE: Years 66 Months 11 Days 7 If less than one day 28 hrs. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Income Tax Representative
11. Industry or business
12. Name George Winder
13. Birthplace Virginia
14. Maiden name Annie Ayres
15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial 6/25/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
18. Funeral director Wm. E. Cook
Address St. Paul & Preston Sts., Balto., Md.

19. 6/24 x6 D. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1946, at 12:00 Noon
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1946, to June 22, 1946,
and that I last saw him alive on June 22, 1946.

Immediate cause of death Bronchogenic carcinoma left lung
with metastasis to the body of the
2nd. vertebra

DURATION
Unknown

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert M. Collison
R. M. COLLISON, M.D. CLIN. M. DIRECTOR
Address V. A. H. Ft. Howard, Md. Date signed 6-22-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—CERTIFICATE OF DEATH 15794

1. PLACE OF DEATH

County Balto.

Village or City Essex. 21

Registration Dist. No. 74

Ward No. 324 Maple ave st.

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. Rt. 13 Box 324 Maple ave

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, end year) Nov 2/1945

7. AGE Years 7 Months 10 Days 15 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto. Co. (State or country)

13. NAME Jerry Zahradka.

14. BIRTHPLACE (city or town) Balto. (State or country)

15. MAIDEN NAME Willid Mary Green

16. BIRTHPLACE (city or town) Balto. (State or country)

17. INFORMANT Mrs. Willid Mary Zahradka (Address) Rt. 13 Box 324 Maple ave

18. BURIAL, CREMATION, OR REMOVAL Place Sacred Heart Date 6/19/1946

19. UNDERTAKER John D Connolly (Address) 718 Eastern Ave Essex

20. FILED 6/18/1946 John D Connolly Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June 17, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

I last saw h_____ elive on _____, 19____; death is held

to have occurred on the date stated above, et_____.m.

The PRINCIPAL CAUSE OF DEATH and related causes of impotence were as follows:

Acute Gastro Enteritis

Date of onset

Other Contributory Causes of impotence: Malnutrition

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) P. J. McCarroll M. D.

(Address) Deputy Medical Examiner

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN
